MEDICAL STAFF BYLAWS
OF
MercyOne New Hampton Medical Center

NEW HAMPTON, IOWA

April 2021

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New Hampton, Iowa

Preamble

MercyOne New Hampton Medical Center (the "Hospital") is an Iowa nonprofit hospital recognized under 501(c)(3) of the Internal Revenue Code of 1996, as amended. The Hospital operates to offer general inpatient and outpatient hospital care, medical care, patient and community education, and other services that promote the general health of the community. The Hospital is qualified as a Critical Access Hospital ("CAH") under the Medicare program and Iowa law, and has executed or will execute one or more agreements (individually and collectively referred to as the "CAH Network Agreement") with a referral hospital (the "Network Hospital").

The Hospital is governed by a volunteer Board of Directors and served by a group of licensed practitioners collectively known as the Medical Staff. The Board of Directors of the Hospital is responsible under law for the management and operation of the Hospital. However, the Medical Staff is in a special position to initially assess and monitor the quality of care and the qualifications and practices of the individuals who comprise the Medical Staff. The Board necessarily delegates to the Medical Staff certain responsibility for medical care and peer review within the Hospital, with the understanding that such responsibility will be exercised in pursuit of the legitimate purposes of the Hospital and Medical Staff, in cooperation with the CEO of the Hospital and under the ultimate authority of the Board.

For these reasons, the Board of Directors hereby organizes the practitioners providing services at the Hospital into the Staff of MercyOne New Hampton Medical Center, subject to the Bylaws and policies of the Hospital, and subject to the following Bylaws, Rules, and Regulations of the Medical Staff.

The Medical Staff is an organizational unit of the Hospital, organized for the purposes and with the authority described in these Bylaws. The Medical Staff is not a separate legal entity or association and is not capable of suing or being sued in its own name. Members of the Medical Staff conducting functions assigned under these Bylaws do so as representatives of the Hospital.

These Bylaws reflect the delegated authority exercised by the Medical Staff and shall guide the Hospital and the Medical Staff in conducting covered affairs, but do not constitute a contract. None of the Hospital, the Medical Staff, nor any member of the Medical Staff conducting delegated responsibilities shall be liable for failure to strictly comply with the terms of these Bylaws or the Rules and Regulations adopted hereunder.

ARTICLE I
DEFINITIONS

As used throughout these Bylaws and Rules and Regulations, the following terms shall have the following meanings:

1.1 **APPLICANT** means a practitioner who has made application for appointment or reappointment to membership on the Medical Staff or the granting of clinical privileges, or both, and shall include individuals who have provisionally been appointed members or who provisionally hold privileges.

1.2 **ALLIED HEALTH PROFESSIONAL** ("AHP") means an individual permitted by law and by the Hospital to render certain health care services in the Hospital, but who is not eligible for clinical privileges.

1.3 **BOARD** means the Board of Directors of the Hospital.

1.4 **BYLAWS** mean the Bylaws, Rules and Regulations of the Medical Staff, unless specific reference is made to the Bylaws of the Hospital.

1.5 **CEO** means the individual appointed by the Board to act as chief executive officer of the Hospital and also refers to his or her designee.

1.6 **CLINICAL PRIVILEGES OR PRIVILEGES** means the permission granted by the Board to a practitioner, subject to availability of appropriate facilities, equipment, staff, and other resources at the Hospital, to provide specified diagnostic and/or therapeutic health services. AHPs do not exercise privileges within this meaning.

1.7 **CREDENTIALING AND VERIFICATION ORGANIZATION** ("CVO") means a contracted centralized credentialing agency that verifies all background data and reference information on a Medical Staff applicants in order to assure that privileges are granted only to qualified individuals, or any other organization with which the Hospital subsequently contracts to provide credentialing and verification services.

1.8 **EXECUTIVE COMMITTEE** means the Executive Committee of the Medical Staff.

1.9 **HCQIA** means the Health Care Quality Improvement Act, 42 U.S.C. §§11101 *et seq.* and the regulations issued thereunder.

1.10 **INVESTIGATION** means, for the purposes of reporting to the National Practitioner Data Bank, an investigation has been undertaken in accordance with Article VII of these Bylaws.

1.11 **MEDICAL DIRECTOR** means the physician designated by the Hospital and his or her designee whose duties include certain responsibilities which are both clinical and administrative as is required by regulations governing critical access hospitals and as are considered necessary to maintain the quality of health care services provided by the Hospital.

1.12 **MEDICAL STAFF YEAR** means the period commencing January 1 each year and ending December 31 the following year.

1.13 **MEMBER** means a practitioner who is appointed by the Board to membership on the Medical Staff and who, therefore, enjoys the prerogatives established for members and is subject to the rules and accountability imposed upon members by these Bylaws and the Bylaws of the Hospital.

1.14 **PEER REVIEW** means: (i) all activities constituting professional review activity under HCQIA; (ii) all activity conducted at the Hospital and described at Iowa Code §§ 147.1-2d and 147.135; (iii) all activity to enforce and apply the responsibilities of membership, the terms and qualifications for membership, and the terms and qualifications for clinical privileges under these Bylaws; and (v) all activity to enforce Hospital policy as it affects a practitioner or practitioners. Peer review is a cooperative effort and includes the activities of officers, directors, agents, and employees of the Hospital, as well as members of the Medical Staff and Allied Health Professionals, including representatives of the Network Hospital when called for under the CAH Network Agreement.

1.15 **PEER REVIEW COMMITTEE** means the committees, officers, agents, contractors and individuals charged under these Bylaws or by the appointing authority with peer review responsibility. Peer review committees under these Bylaws are also referred to as professional review bodies.

1.16 **PEER REVIEW RECORDS** means all records related to the conduct of peer review and includes, without limitation, all records privileged from discovery and/or introduction or use in any administrative or judicial proceeding under Iowa Code §§ 147.1-2d and 147.135 or the corresponding provisions of any other federal statute providing a privilege against disclosure.

1.17 **PHYSICIAN** means a practitioner licensed to practice medicine or osteopathic medicine and surgery in the State of Iowa.

1.18 **PRACTITIONER** means all licensed health care professionals who hold or are eligible to be considered for clinical privileges under these Bylaws (as distinguished from Allied Health Professionals).

1.19 **RESIDENTS** are individuals who are currently enrolled in a graduate medical education program approved by the Department of Health of the state in which the residency program is based. Residents may, as part of their educational program, provide health care services at the Hospital under the supervision of a licensed physician. Residents who hold an Iowa license to practice medicine may also qualify for temporary privileges, called "Resident Privileges", to provide services outside of the scope of their educational program. Such temporary privileges for residents are granted in the same manner as other temporary privileges. Residents are not considered "practitioners" as defined in these Bylaws.

ARTICLE II
PURPOSES AND INTERPRETATION

2.1 **PURPOSES**. The purposes for which this Medical Staff is organized, and the purposes of these Bylaws, are to:

a. Establish an organized structure to which the Board can delegate certain medical care and peer review responsibilities with the understanding the corresponding authority will be used to promote the legitimate objectives of the Hospital and Medical Staff.

b. Appropriately balance the rights and responsibilities of practitioners with the interests of the Hospital, patients, and the Medical Staff as a whole.

c. Promote high standards of diagnosis and care in the Hospital, commensurate with the ability, training, and resources of this Medical Staff and of the Hospital and its professional staff.

d. Establish an appropriate educational setting that will maintain scientific standards and that will lead to continuous advancement in professional knowledge and skill.

e. Establish flexible mechanisms to facilitate communications and resolve disputes.

f. Create the means to comply with the requirements of licensing, accrediting, and regulatory bodies with jurisdiction over the Hospital.

2.2 **INTERPRETATION AND APPLICATION**. These Bylaws shall not impair the ultimate authority of the Board to set policy and make decisions on behalf of the Hospital. These Bylaws establish systems designed to promote smooth and effective operation of the Medical Staff. It is recognized, however, that the Hospital has a small Medical Staff, and that the practicality of these systems will depend upon the resources available at any given time. Accordingly, the Medical Staff, CEO, and Board shall be permitted latitude in applying these Bylaws, to the extent reasonably necessary so that the fundamental purposes of the Medical Staff and these Bylaws may be carried out. Accordingly:

a. The Medical Staff, Board, and Hospital shall be deemed to have complied with these Bylaws whenever action is taken in good faith, in the interest of serving the stated purposes, and in a manner reasonably appropriate to the personnel and resources then available. To the extent necessary to fulfill the purposes set forth above, this provision shall override any contrary or inconsistent provisions contained elsewhere in these Bylaws.

b. Functions normally handled by the Active Staff may be assigned to others whenever there are not enough qualified members in good standing who are available and willing to serve on the matter at hand.

c. Administrative matters, normally handled by the Medical Staff, may, when necessary, be handled by the Board, or a committee established by the Board, or the CEO.

d. The CEO, Hospital administrative or professional staff, Allied Health Professionals, or others may serve on Medical Staff or interdisciplinary committees, with or without vote, by appointment of the Executive Committee, the Board or the CEO, as appropriate to the committee, and subject to any limitations specifically stated in these Bylaws.

e. Certain functions may be carried out in cooperation with, or by delegation to, representatives of the Network Hospital, when called for under the CAH Network Agreement.

f. Time limits and procedures specified in these Bylaws may be temporarily suspended in instances where the Medical Staff is presented with a new issue and seeks to study it to determine the appropriate policy or rule to follow, provided that the period for study and implementation should not exceed ninety (90) days and any practitioner affected by the action is notified.

ARTICLE III
MEMBERSHIP

3.1 **NATURE OF MEMBERSHIP**. Membership on the Medical Staff including assignment to a staff category is granted by the Board following recommendation of the Medical Staff. Application for or acceptance of membership constitutes acceptance of responsibility to participate in the affairs of the Medical Staff, discharge assigned responsibilities, work in aid of the purposes of the Medical Staff and the Hospital, and be governed by these Bylaws and the Bylaws and policies of the Hospital. The prerogatives of membership and of each individual member are expressly limited by these Bylaws and the Bylaws of the Hospital. Each member and each applicant for membership must, as condition for membership, hold or be legally eligible and qualified under these Bylaws for consideration for clinical privileges of the Hospital.

3.2 **ASSIGNMENTS PROVISIONAL**. Assignment to a category of membership is by action of the Board. All initial appointments are provisional pursuant to Section 6.5 of these Bylaws.

3.3 **ACTIVE STAFF**. The Active Staff consists of physicians who meet all the criteria for clinical and admitting privileges, who regularly admit and attend patients at the Hospital, and who are authorized by law and this Hospital and its Medical Staff to assume and discharge the responsibilities attendant to Active Staff status. The Active Staff shall be primarily responsible for achieving the purposes of the Medical Staff including, where appropriate, emergency care and consultation assignments, for executing delegated responsibility of the Board, and for performing the required functions of the Medical Staff. Members of the Active Staff, except during a period of provisional appointment, are eligible to vote, hold office, and serve on committees, including the Executive Committee. In times of staff, resource or other shortage, the needs of Active Staff for beds, procedure rooms, or schedule slots shall have priority.

3.4 **COURTESY STAFF**. The Courtesy Staff consists of physicians who periodically render services at the Hospital, but who do not wish to become members of the Active Staff, or who are not eligible for such appointment. This category will typically include physicians who wish to occasionally admit or co-admit patients to the Hospital, physicians who are eligible for co-admitting privileges but not admitting privileges, or physicians who are recognized specialists willing to serve in a consulting capacity.

3.5 **CONSULTING STAFF**. The Consulting Staff consists of physicians who are recognized specialists willing to serve in a consulting capacity. Members of the Consulting Staff shall provide their service in the care of patients whenever reasonably possible on request of any member of the Active, Affiliate, or Courtesy Staff.

3.6 **AFFILIATE STAFF**. The Affiliate Staff consists of non-physician practitioners who qualify for membership and clinical privileges of the Hospital, including co-admitting privileges. Members of the Affiliate Staff may co-admit or attend any number of patients, provided they meet satisfactory minimums to permit evaluation, and subject to prioritization as described above. Affiliate Staff are not eligible to hold office, but may vote on Medical Staff matters as described in Section 3.10. The Affiliate Staff includes dentists, podiatrists, physician assistants (PAs), advanced registered nurse practitioners (ARNPs), certified registered nurse anesthetists (CRNAs), and any other licensure category approved by the Medical Staff and CEO.

3.7 **TELEMEDICINE STAFF.** The Telemedicine staff consists of Physicians and Practitioners who are responsible for the patient's care, treatment and services via a telemedicine link.

3.8 **RESPONSIBILITIES OF MEMBERSHIP**. Application for or acceptance of membership on the Medical Staff constitutes acceptance of the following responsibilities. The applicant or member shall:

a. Provide prompt, continuous, high quality care to all patients and in all patient care situations for which the practitioner is responsible. This includes avoiding inappropriate delegation of responsibility for treatment, follow-up treatment, diagnosis, or care.

b. If holding admitting or co-admitting privileges, reside in sufficient proximity to the Hospital to permit the practitioner to return to the Hospital promptly, usually within twenty (20) minutes, in order to provide care to patients in urgent and emergent situations.

c. Abide by these Bylaws and the Medical Staff Rules and Regulations, the Hospital Bylaws and applicable policies of the Hospital and Medical Staff. This specifically includes abiding by the policies adopted by Hospital governing sexual harassment and disruptive conduct.

d. Discharge all assigned Medical Staff responsibilities, including emergency on-call responsibility per the schedule maintained by the Hospital, and all committee assignments, which are an inherent part of holding membership and privileges at the Hospital.

e. Participate in continuing education programs as determined by the Medical Staff.

f. Timely complete and sign medical records for all Hospital patients to whom the member provides care.

g. Complete a medical history and physical examination no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure that requires anesthesia services. The medical history and physical examination must be completed by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with Iowa Law and hospital policy.

(1) When the history and physical examination are completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with Iowa law and hospital policy.

(2) The content of complete and focused history and physical examinations is delineated in the rules and regulations.

h. Conduct professional affairs at the Hospital in a courteous and professional manner and maintain satisfactory working relationships with professional colleagues, the Hospital, and its professional staff. Disruptive or unprofessional conduct will be grounds for discipline in accordance with Article XV.

i. Maintain the confidentiality of protected patient health information in accordance with policies adopted by the Hospital and applicable state and federal law.

j. Maintain the confidentiality of Medical Staff peer review records and communications, subject to generally recognized exceptions and specific exceptions in these Bylaws.

k. Strictly abide by the ethics of his or her profession and avoid acts and omissions constituting fraud, unprofessional conduct under state laws and regulations, and conduct that may be subject to penalty or criminal sanction under the Medicare/Medicaid fraud and abuse guidelines or other authority.

l. Strictly refrain from performing any procedures, assuming any patient care responsibilities, or applying for or exercising any specific privileges for which the individual is not currently licensed, trained, privileged, and qualified.

m. Cooperate in any review of his or her (or another's) credentials, qualifications, or compliance with these Bylaws and refrain from directly or indirectly interfering with, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to serve or participate in assigned responsibilities, or otherwise.

n. Work cooperatively with the Hospital Compliance Committee, Executive Committee, and other committees responsible for quality assurance, utilization review, and other Medical Staff functions, and the Hospital Board and Administration, to meet and practice within established practice guidelines, to minimize medically unnecessary lengths of stay in the Hospital, to properly document clinical and diagnostic services ordered or rendered, and to meet all other standards and requirements for compliance with applicable laws and regulations; and generally practice in an efficient manner, conserving healthcare resources, consistent with meeting patient needs.

o. Provide accurate, current, and thorough information in connection with the appointment, reappointment, and privileging process or in response to inquiries from the Executive Committee.

p. Provide prompt reports of certain adverse occurrences. A member must report to the CEO within ten (10) business days the occurrence of any of the following:

(1) The payment by or on behalf of the practitioner of any money in judgment or settlement of any professional liability claim against such practitioner (regardless of by whom the payment is made);

(2) Involuntary denial, loss, or curtailment of the practitioner's license to practice his or her profession or the practitioner's registration (state or federal) to prescribe medications and any voluntary acceptance of any such action during investigation or sanction proceeding against the practitioner;

(3) Any government action or recommendation to exclude the member from participation in Medicare/Medicaid programs; and

(4) Involuntary denial, suspension or termination of membership of the Medical Staff or denial, suspension, termination or curtailment of clinical privileges at another hospital lasting thirty (30) days or longer and any voluntary acceptance of any such action or result during an investigation or in return for not conducting an investigation of such practitioner.

q. Bring to the immediate attention of the Administration the existence of any financial relationships between the physician or a family member of the physician which the physician believes may constitute a disqualifying financial relationship under the Ethics in patient Referral Act ("Stark"), § 1877nn of the Social Security Act, and refrain from making any referral of designated health services to the Hospital that the physician believes are prohibited referrals under Stark.

r. Be bound by Article V in all application, corrective action or other peer review matters.

s. Not write prescriptions for controlled substances for himself/herself or immediate family members.

t. Not order diagnostic tests or procedures on himself/herself or immediate family members.

u. Not treat himself/herself or immediate family members unless during urgent or emergent situations or another qualified provider is not immediately available.

3.9 **MEETINGS AND ATTENDANCE.**

a. Members of the Active Staff are required to attend not fewer than one-half (1/2) of all meetings of the Medical Staff and of all committees to which they are assigned each Medical Staff year.

b. Members of the Medical Staff and Allied Health Professionals are required to attend any meeting of the Medical Staff or of any committee when notified that a case for such member is responsible will be reviewed or when otherwise directed to do so to discuss qualifications, performance, conduct, or patient care issues.

c. A member who fails without good cause as determined solely in the discretion of the Executive Committee to attend the requisite number of meetings or to discharge assigned responsibilities will be subject to review by the Executive Committee and Board of Directors who may take appropriate action regarding the continuation of staff privileges.

3.10 **VOTE.**

a. **Active and Affiliate Staff; Reservation of Certain Voting Rights**. Members of the Active and Affiliate Staff are eligible to vote on matters of a general nature affecting the Medical Staff. By delegation of the authority of the Board of Directors, certain activities are reserved for action by the Active Staff. Actions for which the Active Staff shall be responsible to formulate a recommendation to the Board of Directors include:

(1) Making final recommendations to the Board to approve or deny any applications for Medical Staff membership and clinical privileges or applications for reappointment and renewal of privileges;

(2) Processing requests for peer review or corrective action, conducting investigations or reviews thereon, and making recommendations to the Board; and

(3) Amendment to the Medical Staff Bylaws in accordance with Article XIX.

b. **Courtesy and Consulting Staff**. Members of the Courtesy and Consulting Staff are eligible to serve on committees and vote on committee affairs when such authority is granted by these Bylaws or the appointing authority.

ARTICLE IV
CLINICAL PRIVILEGES

4.1 **NATURE OF PRIVILEGES**. Privileges to practice at the Hospital are granted by the Board following recommendation of the Medical Staff. Application for or acceptance and exercise of privileges constitutes acceptance of the terms and conditions of these Bylaws and the Bylaws of the Hospital. A practitioner may exercise only those clinical privileges specifically granted in accordance with these Bylaws. All care rendered in the Hospital must be on the authority of a practitioner privileged to order such care.

4.2 **QUALIFICATIONS.** The following constitute continuing qualifications for the exercise of privileges at the Hospital. Each member and applicant for membership shall:

a. **Authority Over Staff**. Be authorized by law to give binding directions to nursing and other Hospital staff, such that all staff, when carrying out such directions, will do so on lawful authority.

b. **Training.** Have successfully completed a minimum clinical residency or fellowship (or combination thereof) or qualifying practicum in a relevant specialty which is conducted in whole, or in substantial part, in a hospital setting, which is accredited or approved by the appropriate national board, and which provides a sufficient quantity of patient care experience in which the applicant has had direct, supervised responsibility in each of the areas in which privileges are requested to establish training and competence. The appropriate national board in each case shall be the board or agency, which is itself recognized by the Council of Postsecondary Accreditation of the United States Department of Education to accredit and approve clinical residencies. These shall include, as appropriate, the member boards of the American Board of Medical Specialists (in the case of medical physicians), the certifying boards recognized by the American Osteopathic Association (in the case of osteopathic physicians and surgeons), the Commission on Dental Accreditation (in the case of dentists), the Council of Podiatric Medical Education (in the case of podiatrists), the American Psychological Association (in the case of psychologists), the NCCPA (in the case of physicians assistants), and the equivalent boards or agencies in the case of other fields, if any, which qualify for clinical privileges of the Hospital in the future, in the case of advanced registered nurse practitioners (ARNPs), the Executive Committee may accept certification by the state of Iowa plus the supervised practice experience stated below. The minimum durations of approved training are:

(1) Medical physicians and osteopathic physicians and surgeons - three (3) years.

(2) Dentists - one (1) year.

(3) Podiatrists - one (1) year.

(4) Psychologists - one (1) year plus a minimum one (1) year postgraduate clinical experience which includes a substantial hospital component involving hospital inpatients or outpatients.

(5) ARNPs - 2,000 hours of practice supervised by a physician plus such additional training relevant to specific clinical privileges held or applied as the Executive Committee shall establish generally or in a case-by-case basis.

(6) PAs - Graduate of a physician assistant program approved by the American Medical Association Committee on Allied Health Education and Accreditation (CAHEA).

(7) Other – minimum residencies or equivalent training as established by the Board for such categories, if any, which qualify for clinical privileges.

The training requirements may be waived for practitioners who hold privileges at the Hospital as of the adoption of this provision.

c. **Nature of Practice**. Practice a health care specialty which is consistent with the purposes, treatment philosophy, methods, and resources of the Hospital and its Medical and professional staff; and for which the Hospital has demonstrated need for practitioners or additional practitioners.

d. **Reimbursement**. Be licensed in a specialty, which generally assures the Hospital that services initiated by or under the authority of such practitioner or on such practitioner's certification will be recognized as medically necessary and reimbursable patient care services in a Hospital setting.

e. **Licensure**. Be currently licensed by the State of Iowa to practice his or her profession and to exercise the privileges held or applied for; and be currently registered by the D.E.A. and the State to prescribe consistent with the clinical privileges held or applied for.

f. **Competence**. Demonstrate current competence, including current knowledge, judgment, training, and technique, in his or her specialty area and for all privileges held or applied for.

g. **Conduct Sanctions**. Avoid sanctions based on acts and omissions constituting unprofessional conduct or other grounds for discipline under state licensing laws and regulations, or fraud or other actionable conduct potentially subject to penalty or criminal sanction under the Medicare/Medicaid fraud and abuse guidelines.

h. **Health.** Be free of or have under adequate control any significant physical, mental, or behavioral condition that interferes with, or presents a substantial probability of interfering with, patient care, the exercise of privileges, the assumption and discharge of required responsibilities, or cooperative working relationships.

i. **Health Assessment**. Cooperate openly and fully in any required health assessment.

j. **Liability Coverage**. Maintain in full force and effect valid and collectable coverage for personal professional liability through carriers accepted to do business in the state and acceptable to Hospital in amounts not less than that established by the Board of Directors from time to time after consultation with the Medical Staff, and document the same to the satisfaction of the Hospital. Certificates of insurance shall be provided to the Hospital at least annually, and shall certify that the insurer will provide the Hospital at least 10 days notice prior to termination, non-renewal or change of coverage.

k. **Continuous Care**. Demonstrate current ability and arrangements to provide continuous appropriate care for all patients under his or her care.

l. **HIPAA**. Qualify to participate in Hospital health care operations, such as Hospital and Medical Staff quality improvement, utilization management, peer review, and other functions requiring use of protected health information, as either a member of the workforce, a participant in an organized health care arrangement within the Hospital, or by executing a business associate agreement. Qualification under this provision is further described in the Rules and Regulations.

m. **Medicare/ Medicaid Eligibility**. Certify that he or she is not excluded from providing services under the Medicare or Medicaid programs.

n. **Disqualifying Financial Relationships Under Stark**. Not be involved, directly or indirectly, or through a family member, in a financial relationship with the Hospital that has the effect of prohibiting the Hospital from billing for designated health services referred by such practitioner under Stark. For purposes of this provision, "family member" is defined to mean spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepbrother, stepsister, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, or spouse of a grandparent or grandchild. Applicants and members are required to report the existence of financial relationships; the Hospital will determine whether they have the potential for adverse impact on the practitioner and/or Hospital and may refuse or terminate clinical privileges in the event of a disqualifying financial relationship.

o. **Documentation.** Document the foregoing qualifications to the satisfaction of the Board and Medical Staff. The practitioner shall have the burden of establishing that he or she meets all eligibility requirements, qualifications, and conditions for the exercise of privileges. The CVO will serve to verify all credentials and licensure prior to review by the Medical Staff and Board.

The foregoing qualifications shall not be deemed exclusive if other qualifications and conditions are also relevant to considering an application or granting or exercising privileges in the Hospital.

No member or applicant will be denied privileges based on the individual's sex, race, creed, color, national origin, or based on any other criterion, including handicapping condition, which is unrelated to the delivery of quality patient care in the Hospital or the purposes of the Hospital. In considering an application for privileges, the Medical Staff and Board may consider the ability of the Hospital to provide adequate facilities in support of services for the applicant and his or her patients; the needs of the Hospital for additional members with the applicant's skill and training, and the long-range plans of the Hospital with respect to the emphasis or de-emphasis of particular specialties and the opening, closing, or purchase of specific services, resources, and capacity.

4.3 **TEMPORARY PRIVILEGES**. Temporary privileges, as defined, limited, and conditioned below, may be granted to individuals who would be eligible for consideration of regular privileges under terms of these Bylaws.

a. **Circumstances**. Temporary privileges may be granted:

(1) To applicants for clinical privileges until their application has gone through the credentialing process. The temporary privileges in such case cannot exceed the privileges the practitioner applies for in his or her application.

(2) To practitioners who will provide *locum tenens* coverage for a member of the Medical Staff.

(3) To practitioners on a case-specific basis to permit them to follow specific patients.

(4) To residents who hold an Iowa license to practice medicine and who provide services outside of the scope of their educational program at the Hospital and need temporary privileges to do so. When temporary privileges are granted to residents, temporary privileges are referred to as "Resident Privileges."

b. **Nature and Scope**. Temporary privileges are limited, temporary permission to render specific patient care services in the Hospital. A practitioner holding temporary privileges is not a member of the Medical Staff, acquires no membership rights or interests, and is not considered "privileged" for any purpose other than for a particular case or episode. The practitioner exercising temporary privileges shall not be deemed to have joined the Medical Staff. Upon the expiration of temporary privileges, a practitioner has no continuing rights, status, or privileges on the Medical Staff.

c. **Granting**. Temporary privileges may be granted by the CEO after consultation with the Chief of the Medical Staff or designee. The determination of whether to grant temporary privileges and the scope of any temporary privileges granted within the discretion of the CEO and are made on a case-by-case basis. Temporary privileges may include admitting and co-admitting privileges. An applicant for *locum tenens* or case-specific temporary privileges must first submit an application on a form prescribed by the Medical Staff. Applying for temporary privileges constitutes express acceptance of the terms and provisions of this Section and any related policies, rules and regulations of the Hospital and Medical Staff relating to temporary privileges.

d. **Revocation.** Temporary privileges may be revoked or limited at any time by the CEO, with or without cause, without recourse by the practitioner to the hearing and appeals procedures of Article VIII. In addition, the Chief of the Medical Staff may revoke or limit temporary privileges whenever he or she believes it is necessary to do so in the interest of patient care in the Hospital.

e. **Qualifications**. An applicant for *locum tenens* or case-specific temporary privileges must establish that he or she:

(1) Meets one of the following two requirements:

i. is a member of medical staff at another hospital in a category and with a practice which indicates regular opportunity for review and evaluation of such practitioner's work; or

ii. has otherwise been reviewed and approved to render health services in another health setting, which approval required a review comparable to that required of applicants at the Hospital.

(2) Holds a valid license to practice his or her profession and a valid narcotics permit (if relevant to the requested temporary privileges) in the state of Iowa.

(3) Has professional liability coverage at least equivalent to the minimum types and amounts required for members of the Medical Staff, and

(4) If directed by the CEO, has designated an alternative practitioner who is a member of the Medical Staff with appropriate privileges to provide alternate coverage during times when the applicant for temporary privileges is unavailable.

f. **Resident Privileges.** Temporary privileges granted to residents shall not imply that a resident has committed to practicing in the geographic area served by the Hospital following the training rotation or episode of care for which Resident Privileges are granted.

4.4 **EMERGENCY AUTHORITY**. In the case of medical emergency which threatens the life of a patient or which is likely to lead to serious deterioration in the health of the patient without immediate professional intervention, any practitioner who would be eligible for membership or privileges by virtue of licensure, may be permitted and assisted to attend and treat the patient within the scope of his or her licensure, using facilities of the Hospital, without regard to staff status or lack thereof, provided that no member of the Medical Staff with appropriate privileges to treat the patient is immediately available. When an emergency no longer exists, such practitioner may request temporary privileges to continue to treat the patient, but primary treatment responsibility shall be transferred to a privileged member of the Medical Staff with admitting privileges. The emergency authority available under this section is not a clinical privilege of the Hospital. The authority is exclusively for the benefit of the patient.

4.5 **ADMITTING PRIVILEGES**. Admitting privileges are a clinical privilege of the Hospital granted to qualified practitioners in the same manner as other clinical privileges. Admitting privileges authorize the practitioner to independently initiate admission of a patient to the Hospital and assume responsibility for the overall course of care, subject to the Hospital's admitting standards and procedures. In order to be eligible for admitting privileges, the practitioner must:

a. be authorized by law to prescribe or approve medication which patients may bring with them to, or require while at, the Hospital;

b. be authorized by law to independently perform medical evaluation, including a history and physical examination, and to assume overall responsibility for a patient's care in the Hospital;

c. be authorized to certify to the need for inpatient hospitalization under Medicare/Medicaid and other payer programs designated by the Hospital;

d. be licensed to independently treat conditions in a manner which routinely requires hospitalization;

e. reside in sufficient proximity to the Hospital (office and residence within thirty (30) minutes) to assure that any patient admitted by him or her will receive continuous care; and

f. meet such other conditions as are adopted by the Medical Staff and approved by the Board.

Until changed by action of the Board following recommendation by the Medical Staff, admitting privileges shall be limited to physicians. Other categories may, in future, be considered under Section 6.3c.

4.6 **CO-ADMITTING PRIVILEGES**. Co-admitting privileges are a clinical privilege of the Hospital granted to qualified practitioners the same as other clinical privileges. Co-admitting privileges authorize the practitioner to initiate the admission of a patient to the Hospital for treatment within such individual's licensure, subject to acceptable arrangements with a member of the Medical Staff who has admitting privileges to promptly assume responsibility for the medical evaluation, history and physical examination, and overall medical responsibility for the patient's course of care in the Hospital. In order to be eligible for co-admitting privileges, the practitioner must possess and maintain clinical privileges at the Hospital, must be licensed to treat conditions that routinely require hospitalization, and must meet such other conditions as are recommended by the Medical Staff and approved by the Board. An ARNP or PA holding co-admitting privileges shall have a collaborating or supervising physician arrangement, respectively, with a physician member of the Medical Staff who holds admitting privileges.

4.7 **DISASTER PRIVILEGES**. Disaster privileges are a narrow class of privileges that may be granted when the emergency management plan has been activated and the Hospital is unable to handle immediate needs of patients.

a. The CEO or Chief of Staff may grant disaster privileges.

b. Before granting disaster privileges, the person granting disaster privileges shall require the following proof of identity and qualification (i) a current license to practice the profession and a valid picture I.D. issued by the state, federal or regulatory agency; or (ii) identification indicating that the individual is a member of a Disaster Medical Assistance Team; or (iii) identification indicating that the individual has been granted authority to render patient care services in disaster circumstances by a federal, state, or municipal entity; or (iv) presentation by one or more current members of the Medical Staff with personal knowledge regarding the practitioner's identity and area of licensure.

c. Disaster privileges shall last only until members of the Medical Staff with appropriate admitting or co-admitting privileges are available to assume responsibility for patients under the care of the practitioner with disaster privileges.

d. Disaster privileges are granted solely for the benefit of the patient and confer none of the rights described in Article VIII.

e. A practitioner exercising disaster privileges shall be required to wear or utilize Hospital-issued identification and shall function under the authority of the Chief of Staff or his or her designee.

f. If disaster privileges will last longer than twenty-four (24) hours, the Executive Committee shall, as soon as possible, begin the process for verification using the same standard as for case-by-case granting of temporary privileges and complete the process within a reasonable period of time.

4.8 **TELEMEDICINE AND REMOTE SITE PRIVILEGES.**

a. Providers/Practitioners who are responsible for the patient's care, treatment and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with these Bylaws, accreditation requirements and applicable law.

b. Providers/Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms;

1. The Providers/Practitioners shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set forth in these Bylaws.

2. The Providers/Practitioners shall be credentialed and privileged by the Hospital in accordance with the applicable procedure set for in these bylaws with the exception that the credentialing is completed "by Proxy" (A person authorized to act for another) according to the information and/or privileging decision from the distant site. This decision may be relied upon by the Medical Staff and Board in making its recommendation/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

a) The distant site hospital providing the telemedicine service is a Medicare-participating hospital.

b) The individual distant site Provider/Practitioner is privileged at the distant site hospital providing the telemedicine services, which provides a current list of the distant site Providers/Practitioners' clinical privileges at the distant site hospital.

c) The individual distant site Provider/Practitioner holds a license issued or recognized by the State of Iowa.

d) The Hospital has evidence of an internal review of the distant site Provider/ Practitioner's performance of these Clinical Privileges and sends the distant site Hospital such performance information for use in the periodic appraisal of the distant site Provider/Practitioner.

4.9 **REFERENCE PRACTITIONERS**. Reference Practitioners are those practitioners who are granted limited permission to refer their patients to the Hospital for outpatient diagnostic tests or therapeutic procedures to be performed by Hospital personnel without any personal service performed by the Reference Practitioner. Reference Practitioners are those practitioners who do not wish to apply for or do not qualify for privileges to admit or provide services for patients at the Hospital. Reference Practitioners are not members of the Medical Staff and do not hold privileges. All questions by Hospital Staff regarding orders from Reference Practitioners for outpatient tests or procedures to be performed by Hospital Staff must be clarified with the reference practitioner. If questions remain, the orders must be approved and countersigned by a member of the Active or Courtesy Staff or the Hospital may also refuse to carry out the order for any reason. Reference Practitioners must be licensed in the diagnostic or therapeutic modality referred.

4.10 **ADMINISTRATIVE AND CONTRACT PHYSICIANS**. Certain practitioners provide services under contract to the Hospital after first qualifying for clinical privileges in the same manner as other practitioners. If the contract or terms of appointment of any such administrative or contract physician so provide, the practitioner's Medical Staff membership and privileges may be conditioned on continued appointment or contract with the Hospital, and upon termination of such appointment or contract, the practitioner may be deemed to have consented to automatic relinquishment of all Medical Staff membership and/or clinical privileges without any right to hearing, appeal or other procedures, notwithstanding anything to the contrary contained elsewhere in these Bylaws.

4.11 **CLOSURE OF SERVICES**. The fact that a practitioner holds particular clinical privileges in a particular clinical service area shall not preclude the Hospital from placing exclusive responsibility for such clinical service area in a designated practitioner or group thereby limiting the exercise of privileges in such clinical service area, provided, that when the Hospital does so, the Executive Committee shall approve the source of such contracted services.

4.12 **LEAVE OF ABSENCE**. Any practitioner who anticipates being absent from his or her practice at the Hospital for six (6) weeks or longer may request leave of absence from the Hospital for a period of not more than twenty-four (24) months by notifying the CEO and the Chief of the Medical Staff, in writing, of the date of commencement, expected duration, and reasons for the leave of absence. In addition, any practitioner who has not exercised his or her clinical privileges at the Hospital for a continuous period of three (3) months and any practitioner described in Section 7.13g may be involuntarily placed on leave of absence by action of the Executive Committee. During a period of leave of absence, no participation in Medical Staff activities shall be required, and all clinical privileges shall be suspended.

4.13 **RETURN FROM LEAVE OF ABSENCE**. Return from leave of absence shall be in accordance with conditions established by the Executive Committee, which may include health assessment or demonstration of current compliance with all qualifications for privileges.

4.14 **RESIGNATION.** A practitioner may resign his or her membership or clinical privileges, including individual clinical privileges as follows:

a. **Voluntary Resignation**. A voluntary resignation is a decision by an individual to surrender either one or more clinical privileges or Medical Staff membership based on that individual's personal preference at a time when that individual is not "under investigation," or when such resignation is not in lieu of conducting such an investigation under Article VII of these Bylaws. A practitioner may submit a voluntary resignation at any time, and such resignation is effective upon acceptance by the Medical Staff or its Executive Committee. The Medical Staff or Executive Committee may condition acceptance upon orderly completion of records or other pending responsibilities of the practitioner.

b. **Resignation While Under Investigation**. A resignation by a practitioner (i) who is under investigation as defined in the Definitions Section and described in Article VII of these Bylaws, (ii) who resigns in lieu of the Executive Committee or Hospital conducting an investigation, or (iii) where such resignation is part of the terms or conditions of the negotiated resolution of peer review activity, shall not be effective until submitted to and approved by the Board. The Board may condition acceptance upon the orderly completion of records or other pending responsibilities of the practitioner or the fulfillment of negotiated terms.

c. **Reporting.** The CEO shall advise the Executive Committee and Board when a resignation under this Section requires reporting to the Board of Medical Examiners or the National Practitioner Data Bank and take steps to assure timely reporting.

d. **Voluntary Resignation of Privileges**. A practitioner's request to limit or voluntarily resign individual clinical privileges as a means or mechanism to avoid on call responsibilities may be denied by the Executive Committee without forwarding a formal recommendation to the Board. Such denial does not trigger any right to hearing, appeal or other procedures, notwithstanding anything to the contrary contained elsewhere in these Bylaws.

4.15 **MODIFICATION OF CLINICAL PRIVILEGES**. The Executive Committee, may on its own initiative based on a practitioner's practice patterns and experience at the Hospital, recommend modification of privileges held or applied for, at the time of reappointment or otherwise. When based on lack of activity in the area of the affected privilege, the modification shall not be deemed reportable unless it is contested by the practitioner and there is a determination such modification is based on lack of demonstrated competence in the subject privileges.

4.16 **DENTISTS AND PODIATRISTS**. Dentists and podiatrists granted surgical privileges shall exercise such privileges subject to the supervision of the Chief of the Medical Staff or a designated member of the Active Staff. Dentists and podiatrists do not qualify for admitting privileges but may qualify for co-admitting and other privileges.

4.17 **CRNAs**. CRNAs function at the Hospital as dependent practitioners, and are not eligible for admitting or co-admitting privileges.

4.18 **TRAINING**. All physicians or practitioners performing procedures at the Hospital for purposes of undergoing training or evaluation outside the course of an approved medical education or residency program shall be first credentialed and privileged for all such activities in accordance with the provisions of Article VI.

ARTICLE V
PEER REVIEW PRIVILEGE AND IMMUNITY

5.1 **INTERPRETATION**. It is the intention of these Bylaws to define the term peer review in the broadest terms and to secure to those who engage in any aspect of peer review in, at, for, or on behalf of the Hospital and its Medical Staff, the broadest possible privilege and immunity from liability. This Article V and these Bylaws will be interpreted to effectuate this objective. The privileges and immunities set forth in this Article V shall be cumulative of all other protections provided by law.

5.2 **AUTHORIZATION AND RELEASE**. The following shall be express conditions on the application for, or the holding or exercise of, membership or privileges at the Hospital. Each applicant and each member hereby expressly:

a. Authorizes representatives of the Hospital and Medical Staff to solicit, obtain, review, and act upon information bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct;

b. Authorizes any other individual and organization to provide information to representatives of the Hospital and Medical Staff bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct, and agrees to execute authorizations and releases to facilitate obtaining such information from third parties at the request of the Hospital;

c. Authorizes other members and representatives of the Medical Staff and representatives and employees of the Hospital to provide information bearing upon, or reasonably believed to bear upon, the practitioner's professional ability, qualifications, and conduct;

d. Consents to inspection of records and documents that may be material to evaluation of his or her professional ability, qualifications, and conduct, authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying, and agrees to execute authorizations and releases to facilitate obtaining or reviewing such records and documents at the request of the Hospital;

e. Agrees to provide accurate, current, and complete information in connection with the appointment, reappointment, privileging, quality improvement, and corrective action processes at the Hospital, or in specific inquiries from the Medical Executive Committee or the Board, or as a continuing obligation under these Bylaws;

f. Agrees to immediately inform the CEO of any material changes or developments affecting or changing the information provided in or with his or her application;

g. Agrees to cooperate with Medical Staff leadership and committees in the conduct of peer review activities involving him or her, which includes appearing at interviews, answering questions and working within the peer review structure described in these Bylaws;

h. Releases from liability, to the fullest extent permitted by law, all officers, members and representatives of the Medical Staff and all officers, directors, employees, and representatives of the Hospital, for their acts performed in connection with conducting peer review activity or furnishing information in connection with peer review activity on behalf of the Medical Staff and Hospital;

i. Agrees not to commence a legal action against the Medical Staff or Hospital or against any officer, member, or representative of the Medical Staff or any officer, director, employee, or representative of the Hospital, for any investigation or peer review activity taken in accordance with the provisions of the Bylaws;

j. Agrees to exhaust all remedies afforded by these Bylaws before resorting to legal action in connection with all peer review matters;

k. Authorizes representatives of the Medical Staff and the Hospital to disclose to other hospitals, medical associations, licensing boards, practice groups, and similar organizations information regarding his or her professional abilities, qualifications, and conduct, including information about current and past membership and privileges and results of peer review activities at the Hospital, in connection with such other party's peer review activities, and releases the Medical Staff and its officers, members and representatives and the Hospital and its officers, directors, employees and representatives for so doing to the fullest extent permitted by law; and

l. Acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and the exercise of the clinical privileges or practice authority at the Hospital.

As used in this Section, the term "this Hospital and its authorized representatives" means Mercy Medical Center – New Hampton, its parent or affiliate organizations, the members of its Board of Directors and their appointed representatives, the CEO and his or her designee(s), any Hearing Officer, Presiding Officer and all members of any hearing committee, consultants to the Hospital, the Hospital's attorney and his or her staff and partners, all members of the Medical Staff, and representatives of the Network Hospital when providing services to or conducting functions on behalf of the Hospital pursuant to the CAH Network Agreement. The term also includes Allied Health Professionals and Hospital employees who have responsibility for obtaining, giving, evaluating, or acting upon information in the peer review context or who otherwise participate or provide information.

5.3 **SCOPE OF PEER REVIEW.** Each officer and committee of the Medical Staff is hereby constituted a peer review body and each such officer and committee and their agents (including the CEO and his or her designees, and representatives of the Network Hospital when acting pursuant to the CAH Network Agreement) are authorized to engage in peer review activity and to investigate and make recommendations to the Executive Committee concerning applicants or members and privileges or on the quality of patient care at the Hospital.

5.4 **INFORMATION PRIVILEGED**. Peer review records shall, to the fullest extent permitted by law, be confidential and privileged from discovery or disclosure, except as otherwise provided in these Bylaws.

ARTICLE VI
APPOINTMENT AND PRIVILEGING

6.1 **APPLICATION FOR APPOINTMENT OR PRIVILEGES**. All applications for membership or privileges must be in writing, signed by the applicant, and submitted on a form prescribed by the Hospital. The application must indicate the category of membership and the particular privileges requested. The applicant has the burden of producing adequate information and documentation for a proper evaluation of his or her application. The application form shall contain the applicant's agreement to be bound by the terms of the Hospital Bylaws, the Medical Staff Bylaws and Rules and Regulations in all matters relating to consideration of the application (whether or not the application is acted on favorably), and in all matters pertaining to his or her practice at the Hospital if granted membership and privileges.

6.2 **APPLICATION**. The application shall require detailed information and documentation concerning the applicant's education, training, experience, licensure, clinical affiliations, malpractice claims experience, and insurance status; any challenges to (limitations on), or suspension or termination of the practitioner's licensure, medical staff membership, or clinical privileges in any state or any facility; references from others with knowledge of his or her professional competence and character; and such other information as may be deemed relevant by the Hospital.

6.3 **APPLICATION REVIEW PROCESS**.

a. **CVO**: The Hospital may contract with or utilize the services of a CVO or other third party to assist with the gathering and verification of all or any portion of the application materials. All applicants shall cooperate fully with such organization (currently Mercy Health Network, but the designated CVO may be changed from time to time by the Hospital) or any other party assisting the CEO or the Hospital in carrying out their responsibilities under these Bylaws. References in this Section 6.3 to specific credentialing and verification actions by the CEO include those functions delegated to the CVO per the written arrangement with the CVO and applicable policies of the Hospital.

b. **Initial Review**: The completed application must be submitted to the CVO. The CVO will initially review the application for completeness and verify the references, licenses, and other information. The CVO will query the National Practitioner Data Bank and check the OIG- and GSA-excluded practitioner websites. They will inform the applicant if the application is incomplete, if there are any problems in verifying the information contained in the application or if any additional information is required. Similar notification may be provided at any subsequent stage of review if it is determined that additional information is needed. Upon such notification, it shall be the applicant's obligation to obtain and furnish the required information. If the required information is not received by the CVO within sixty (60) days thereafter, the application will be deemed withdrawn, and the applicant will be so informed by the CVO. Termination of the application process under this Section shall not be grounds for hearing or appeal. Time periods for the processing of any application shall be tolled during any period between request for additional information and receipt of the requested information. When collection and verification is satisfactorily accomplished, the CVO will assemble the application and all supporting materials and present to the CEO for review and subsequent presentation to the Medical Staff and Board of Directors.

c. **Questions of Professional Eligibility**: Applications by individuals, who, by virtue of licensure status or other factors, clearly are not eligible for clinical privileges at the Hospital, or applications seeking privileges which are not then considered available at the Hospital, need not be accepted and processed by the organization or CVO. Applications by individuals who may be eligible but whose professions have not previously been granted independent clinical privileges at the Hospital (or the type of privileges being sought), or a request for privileges involving technologies not currently used in the Hospital, may be tabled pending study by the Board, the CEO, and the Medical Staff, of the appropriate role of the practitioner or availability of the privileges, if any, at the Hospital. Such study may be conducted in any manner deemed appropriate by the Board, including referral to the Executive Committee for advice. Appropriate action on the application under this Article may be taken following conclusion of the study.

d. **Investigation**: Upon receipt of the completed application and supporting materials, the Executive Committee may conduct any investigation it deems necessary and appropriate, or may appoint an individual practitioner or an *ad hoc* committee to assist in an investigation of the applicant. When the applicant is a non-physician, the advice of another member of the applicant's profession may be sought as to the applicant's apparent qualifications to exercise the privileges requested. The Executive Committee may also meet personally with the applicant and may seek advice from the CEO or any other source when the Executive Committee deems it helpful to do so in considering an application.

e. **Executive Committee Review**: Within sixty (60) days after completion of verification the Executive Committee shall submit to the CEO a recommendation that the applicant be either provisionally appointed to the Medical Staff and provisionally granted privileges or denied Medical Staff membership and clinical privileges, or the Executive Committee may defer the application for up to thirty (30) additional days for further consideration. A recommendation for appointment and privileges shall include the category of Medical Staff, specific privileges, and any limitations thereon. The Executive Committee may also advise the CEO and the Board of any matters of special concern presented by the application.

f. **Notice of Recommendation and Subsequent Action**: Upon receipt of the Executive Committee's recommendation, the CEO may notify the applicant of the nature of the recommendation. If the recommendation is one for which the applicant may request a hearing under these Bylaws, the CEO shall also provide the applicant with a summary of the grounds for the recommendation; shall advise the applicant that he or she may appeal the recommendation within thirty (30) days; shall provide the applicant with a summary of the hearing rights and procedures; and shall take no further action for thirty (30) days. If within thirty (30) days the applicant requests a hearing, the recommendation will not be forwarded to the Board, and the hearing and appeal procedures set forth these Bylaws will apply. If the recommendation is not one for which the applicant may request a hearing, or if no hearing is requested within thirty (30) days after notice of recommendation, the CEO will submit the recommendation to the Board of Directors for final action as described in subparagraph 6.3g, below.

g. **Board Action**: At its next regular meeting following receipt of the Executive Committee's recommendation (or at a special meeting called for this purpose), the Board will act on the matter. In its discretion, the Board may defer action for a specified period of time, during which time it may refer the matter back to the Executive Committee for specified further action, or seek advice from the CEO, legal counsel, or others on matters of concern. The Board's decision shall be final and conclusive, except that if the Executive Committee's recommendation and one for which the applicant could not request a hearing, and the Board's decision is contrary to the Executive Committee's recommendation was one for which the right to a hearing is provided in these Bylaws, the applicant may request a hearing. The applicant and the Chief of the Medical Staff will be promptly notified of the decision of the Board.

h. **Withdrawal:** An applicant may at any time withdraw his or her application from further consideration in which case the application shall not be transmitted to the Board for action. An application, which is withdrawn prior to a final adverse recommendation by the Executive Committee or the conduct of a hearing under Article VII, shall not be deemed rejected or denied.

i. **Burden of Proof**: The applicant has the burden of proving in application proceedings or in any subsequent hearing and appellate review that he or she meets all of the requirements for requested privileges or category of membership under these Bylaws and Rules and Regulations, and under the Bylaws and policies of the Hospital.

6.4 **DURATION OF APPOINTMENT**. Each regular appointment or reappointment to the Medical Staff and each grant of privileges will be for a maximum period of two (2) years. Reappointment must be sought every other year, based on odd/even years of the current year and the year of the applicant's birth, unless a shorter period is specified at the time of appointment or unless earlier terminated, suspended, or limited in accordance with these Bylaws. Reappointment shall be considered by the Board quarterly.

6.5 **PROVISIONAL STATUS**. Initial appointment to the Medical Staff (other than Honorary Staff) and initial grants of clinical privileges, will be provisional so that observation of the practitioner's exercise of privileges may be completed prior to final action on the application. The provisional period shall therefore constitute an extension of the application process subject to the following terms and conditions:

a. **Duration**. Provisional appointment and privileges last for a minimum of twelve (12) months and may be extended by the Executive Committee for an additional period not to exceed twelve (12) months.

b. **Proctor; Limitations**. During the provisional period, the practitioner may be required to function under the supervision of a proctor appointed by the Chief of the Medical Staff for the purpose of permitting a period of observation of the practitioner in the exercise of clinical privileges. Supervision, reporting, consultation, or other such conditions may be imposed during the provisional period to assist in observation of the practitioner. Because of the observation and evaluation purpose of the provisional period, the imposition of such conditions shall not be deemed to be a limitation or rejection of privileges, and shall not give rise to hearing or appeal.

c. **Responsibilities**. The practitioner must discharge all responsibilities of the category of staff and/or privileges for which he or she has been granted provisional status, including attendance at meetings as required.

d. **Final Appointment or Rejection**. At the conclusion of the provisional period, or sooner, in the Executive Committee's discretion, the Executive Committee will consider and take final action upon the application in the same manner as with new applications for appointment or privileges. The Executive Committee shall consider the relevant information related to the applicant's practice and the report and recommendations of the proctor (if any) during the term of, or at the end of, the provisional period.

e. **Insufficient Activity**. A practitioner who has been on provision status for twelve months or longer, but who has not attended a sufficient number of patients during that time to permit the proctor and the Executive Committee to adequately assess the applicant's competence, may be denied membership and clinical privileges on that ground or, in its discretion, the Medical Executive Committee may extend the provisional period for a maximum duration of twenty-four (24) months after which, if appointment is deferred due to continued lack of activity, the application will be administratively withdrawn as incomplete.

6.6 **REAPPOINTMENT/RENEWAL PROCESS**.

a. **Written Application**: Every other year, each practitioner with clinical privileges at the Hospital must submit to the CEO or designee a signed, completed application for reappointment and renewal of privileges at least thirty (30) days prior to the expiration of their current appointment. Failure to submit a completed application in the time required may be considered a voluntary resignation from the Medical Staff and a voluntary relinquishment of privileges. The CEO need not accept or process for reappointment the application of a practitioner who has had no significant contact with the Hospital during the preceding year, absent an acceptable showing of intent by such practitioner to utilize the requested privileges in a significant way during the succeeding appointment period. Denial of reappointment on this basis or voluntary resignation due to failure to submit a completed application shall not entitle the practitioner to hearing or appeal or give rise to a report to the National Practitioner Data Bank or State Department of Health and Human Services Credentialing Division.

b. **Procedures**: The CVO shall send the reappointment applications to all practitioners scheduled for reappointment/renewal of their clinical privileges. The CVO shall also send a copy of the practitioner's Hospital-specific delineation of privileges. Completed applications for reappointment/renewal shall be submitted to the CVO in accordance with the same procedures for initial appointment. The CVO shall verify applications following the same procedures outlined for new appointments, and forward completed appointments to the CEO.

c. **Information:** In reviewing applications for reappointment and renewal of privileges, the Executive Committee and Board will not be limited to review of information supplied within or in support of the application, but may review and consider any other records and information deemed relevant to their review. Without limitation, this may include review of such items as Board, Medical Staff, or committee meeting minutes or records; utilization review, quality reports; records of civil malpractice proceedings; insurance documents; records of the Board of Medical Examiners or other governmental agencies, including the National Practitioner Data Bank; personal medical records of the applicant; complaints or comments from other members of the Hospital staff, the CEO, patients, or members of the public; and any other relevant documents or correspondence. The practitioner may be required to submit to a health assessment. The Executive Committee and Board may also consider whether the practitioner has actually exercised all the requested privileges with sufficient frequency since the time of last appointment or reappointment to indicate current proficiency.

d. **Status Pending Review**: Upon receipt of complete, timely application for reappointment, the existing membership and privileges will remain effective until final action by the Board, unless otherwise modified, suspended, or revoked under these Bylaws.

6.7 **NEW OR EXPANDED PRIVILEGES**. Any existing Medical Staff member may request new or extended privileges at any time, subject to the following:

a. Documentation of completion of a satisfactory training or certification program must be submitted with the application.

b. Verification of the program will be completed by Administration.

c. Other materials deemed appropriate for this application may be requested.

d. Granting of these privileges will follow Executive Committee review and recommendation and Board of Directors' action.

6.8 **RECLASSIFICATION**. An existing member desiring reclassification to another category of staff shall apply on a form approved by the Executive Committee after consultation with the CEO. The individual's eligibility for reclassification will be based on whether, during the year preceding application for reclassification, the practitioner met all of the requirements for the category of staff requested. A request for reclassification as a means to avoid call responsibilities may be denied by the Executive Committee without triggering hearing and appeal rights.

6.9 **APPLICATION FOLLOWING ADVERSE DECISION**. No application for Medical Staff membership or clinical privileges will be received or processed if, within the prior twenty-four (24) months, the applicant has resigned while under investigation, has been denied membership, has been denied the same or similar privileges at the Hospital, or has had his or her membership or the same or similar privileges revoked, unless in its sole discretion the Executive Committee or the Board determines that there is good cause under circumstances of the particular case for considering the application. In such cases, the CEO will notify the applicant as to whether or not the application has been received and will be processed. No hearing or appeal shall be available in such cases.

6.10 **PROCTORING**. From time to time, these Bylaws, the Rules and Regulations, or the Policies of the Hospital may require proctoring of an applicant, member, practitioner holding temporary privileges, or other, by a Committee, member, officer, or other qualified individual. The purpose of such observation is to facilitate the work of the Medical Staff and the conduct of peer review, not to provide or enhance the quality of care to any individual patient. Individuals who are designated to proctor, supervise, or monitor an applicant or a member under these Bylaws are carrying out a Medical Staff function in support of the Medical Staff's peer review responsibility. Assignment to or discharge of any such role shall not imply or have the effect of creating a physician-patient relationship or a duty on the part of the proctor, supervisor or monitor to participate or intervene in the care of an individual patient.

ARTICLE VII
CORRECTIVE ACTION

7.1 **INFORMAL RESOLUTION**. All practitioners are encouraged to resolve problems on a voluntary, informal and professional basis whenever possible. When voluntary informal resolutions outside the Medical Staff organization have not been successful, the matter may be referred to the executive Committee which may opt for further informal action before initiating corrective action under this Article VII.

7.2 **MEANING AND INTERPRETATION**.

a. "Corrective Action" refers to actions or recommendations that are adverse in some material respect toward a practitioner's membership or privileges and that result from the processes framed in this Article VII *or* inherent in the Board's overall authority for the Hospital. Corrective action is distinguished from the processes set forth in Section 7.5 in these Bylaws to determine if corrective action is warranted.

b. Corrective action and the processes described herein are part of peer review. Corrective action is based upon issues involving a member's professional competence, conduct, qualifications, or conformance to the conditions of membership and privileges that are believed to deviate from the standards, conditions, qualifications, and expectations in the Hospital or Medical Staff Bylaws, Rules and Regulations, and policies.

c. Because of the size of the community and Medical Staff, all or nearly all members of the Medical Staff are in economic competition with one another or refer or receive referrals from one another. The fact of such competitive or business relationships shall not preclude a member from discharging responsibility to participate in corrective action process and the hearing process described in Article VIII allow for an independent hearing officer or hearing committee without such competitive or business relationships to consider the matter and make findings.

d. The corrective action process is intended to help the Medical Staff and Board determine the facts and apply standards that are consistent with the Hospital's legitimate patient care, legal and operational needs. The Executive Committee is authorized upon consultation with the CEO to utilize the services of outside reviewers and consultants, including the Network Hospital, as a source of independent analysis to assist the Medical Staff in reaching its findings or recommendations, provided, however, the Executive Committee is not required under these Bylaws to engage external peer reviewers in any particular case.

e. The Board believes that Medical Staff participation in quality and peer review initiatives to advance the standards adopted by the Medical Staff and Board is essential to the Hospital's mission and the welfare of the community served. Accordingly, members of the Medical Staff engaged in corrective action process in accordance with these Bylaws do so as representatives of the Hospital and entitled to all protections provided by the Hospital to its agents and representatives.

7.3 **CRITERIA FOR INITIATION**. The corrective action process may be initiated whenever the body or committee initiating it has reason to believe that:

a. The practitioner has provided or is providing patient care below applicable professional standards for quality or timeliness.

b. The practitioner has engaged or is engaging in conduct which is contrary to the conditions of membership or the standards of conduct in Hospital and Medical Staff Bylaws, policies, and Rules and Regulations.

c. The practitioner has ceased to meet all of the required qualifications for his or her category of membership or clinical privileges or to satisfy all of the basic requirements for membership and privileges.

7.4 **PROCEDURE FOR INITIATION.**

a. **Who May Initiate**. Any of the following may request that the corrective action process be initiated:

(1) Any member of the Medical Staff;

(2) Any committee of the Medical Staff;

(3) The CEO; and

(4) The Board or the Board Chair.

b. **Written Request**. A request for corrective action must be in writing and be supported by reference to specific facts or activities that the initiating party believes may support corrective action. If the Executive Committee initiates the request, it shall make appropriate record of the reasons. The request should include:

(1) the facts that support the need for investigation, study, or review;

(2) if the requestor does not have first hand knowledge of the facts, the basis for believing that the facts exist; and

(3) the extent of prior discussion or interaction (including prior corrective action) with the affected practitioner on the issue(s) described in the request.

c. **Initial Review**. The Executive Committee shall review the request with the CEO and in consultation with the CEO determine whether the information reported, if true, appears to warrant corrective action or another response. The Executive Committee is encouraged, but not required, to meet with the affected practitioner before initiating an investigation as described in Section 7.5 of these Bylaws, below.

(1) The Executive Committee is encouraged in its initial review and discussion with the CEO to determine if there can be an informal resolution of issues without resort to investigation and corrective action.

(2) If corrective action may be warranted, the Executive Committee, in consultation with the CEO, shall determine a plan of review, study or investigation.

(3) If corrective action would not be warranted, the Executive Committee is encouraged to meet with the party who requested the action to review its conclusion.

(4) The Executive Committee may determine corrective action would not be warranted while still recommending follow-up action such as individual or Medical Staff education or review and revisions of policies and procedures.

7.5 **INVESTIGATION**. Investigation by the Medical Staff is a formal process of review. If the Executive Committee concludes an investigation is warranted, it shall document the decision to initiate an investigation in the minutes and notify the affected practitioner in writing that an investigation has been initiated. A practitioner is not "under investigation" by the Medical Staff, simply because corrective action process has been initiated.

a. The Medical Executive Committee may investigate or may assign that task to an appropriate Medical Staff officer or standing or ad hoc committee. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as possible. The report may include recommendations for appropriate resolution, which may include corrective action.

b. The affected practitioner should be given an opportunity to provide information in a manner and upon such terms as the investigation body deems appropriate. The individual or body investigating the matter may interview the practitioner. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by circumstances, including precautionary or summary suspension, termination of investigative process or other action.

c. The preceding shall not prevent the Board or Administration from investigating a practitioner under separate procedures adopted by them.

7.6 **INTERVIEWS**. The Executive Committee and any body or committee conducting an investigation or charged with review or study to determine if an investigation or corrective action may be warranted, may request the affected member to appear for an interview to answer questions, provide information or explain the issues under review. Any such interview shall not constitute a "hearing" as that term is used in Article XIII, nor shall the procedural rules with respect to such hearings apply. The member shall not be entitled to bring an attorney or representative to the interview. Failure to attend as requested constitutes independent grounds for corrective action.

7.7 **SUPPORT BY ADMINISTRATION**. The CEO shall endeavor to provide or arrange for necessary staff and other support to assist with the corrective action process, including arrangements with outside reviewers when warranted. The CEO shall endeavor to assure the grounds for corrective action relate directly to and are consistent with the Hospital's legitimate patient care, legal and operational needs. The CEO shall also advise on procedure and determine which actions and recommendations are reportable to the National Practitioner Data Bank, the Board of Medical Examiners, or any other body or agency with jurisdiction.

7.8 **FOCUSED REVIEW AND MONITORING**. The Executive Committee may impose a requirement that a practitioner's clinical practice activities or records be concurrently monitored. Focused review and monitoring is for the purpose of gathering information and is not corrective action and does not entitle a practitioner to hearing and other rights under Article VIII of these Bylaws.

7.9 **EXECUTIVE COMMITTEE ACTION**. As soon as practicable after the conclusion of the investigation, the Executive Committee shall take action. Without limitation, the Executive Committee may:

a. determine not to take corrective action and, if the Executive Committee determines there was no credible basis for the investigation, remove any adverse information from the member's credentials file;

b. impose corrective action if the corrective action does not entitle the member to hearing rights under Article VIII;

c. recommend corrective action that does entitle the member to hearing rights under Article VIII, subject to giving the member notice and the opportunity to request a hearing;

d. file a report with the appropriate licensing body based on the issues under review;

e. enter into a negotiated settlement with the practitioner governing future conduct and conditions;

f. work cooperatively with a member and with any program, agency or provider engaged in assessing the member's professional competence, conduct or qualifications, or assisting the member with health, conduct, performance or practice issues;

g. impose precautionary/summary action, subject to the terms of Section 7.12 of these Bylaws;

h. pursue informal resolution;

i. request the Board or Administration to take over or conduct an investigation if the Executive Committee determines it is unable to satisfactorily do so itself or the Board or Administration is the more appropriate party to do so; and

j. take other actions deemed appropriate under the circumstances.

7.10 **EXECUTIVE COMMITTEE ACTION WITHOUT HEARING RIGHTS**. The Executive Committee, following investigation, may impose any of the following corrective actions or take any of the following steps without triggering hearing rights under Article VIII:

a. caution, warn, censure, or reprimand any member in writing, with a copy placed in the member's credentials file along with any response furnished by the member;

b. impose automatic sanctions;

c. impose sanctions related to incomplete and delinquent records based on policy approved by Medical Staff;

d. require long-term monitoring or review of a practitioner's practice or records as a result of an investigation;

e. require that the practitioner provide specified information which may bear upon his or her professional competence, conduct and qualifications, including health assessment;

f. remove any member from any committee chairmanship or committee assignment;

g. impose precautionary action for up to fourteen (14) days while an investigation is ongoing; precautionary action lasting longer than fourteen (14) days will entitle a member to a hearing, but the hearing may be combined with the hearing on the final recommendation; and

h. reassign any member from one category of staff to another category of staff for failure to attend the requisite number of staff or committee meetings or failure to meet other continuing requirements for a particular category.

7.11 **SUBSEQUENT ACTION**.

a. If corrective action entitling a practitioner to hearing rights is recommended by the Executive Committee, that recommendation shall be transmitted in writing to the member by the CEO. The member shall then be entitled to request a formal hearing as set forth in Article XIII. The recommendation shall not be transmitted to the Board for action until it is determined whether the member has exercised his or her right to a hearing, and, if a hearing is held, until after the decision of the hearing officer or hearing committee is considered.

b. The Executive Committee can always reconsider its recommendation in light of new information and alter its recommendation.

c. Once a practitioner has waived the right to a hearing, the Executive Committee shall forward its final recommendation to the Board of Directors. Only the Board can impose corrective action entitling the member to hearing rights, except that the Executive Committee may impose longer-term precautionary action entitling the practitioner to a hearing.

7.12 **PRECAUTIONARY AND SUMMARY ACTION**.

a. **Authority**. The Executive Committee and Board President in consultation with the CEO, and the CEO in consultation with the Board President, have authority to suspend or limit the exercise of privileges on a precautionary and summary basis pending investigation and a determination as to whether corrective action is warranted. Precautionary/summary action is not disciplinary in nature. It is a precautionary step based on the best available information pending full investigation. Once imposed, the Executive Committee may limit, enlarge, or revoke any precautionary action it has imposed.

b. **Precautionary Action**. The Executive Committee, Chief of Staff, CEO or Board President shall have the authority, whenever in the opinion of the individual imposing there is credible basis to believe that summary action is immediately necessary for the protection of patients, staff or the Hospital pending full investigation, to impose precautionary action. Such precautionary action shall become effective immediately upon imposition or as otherwise set forth in the notice to the affected practitioner. The practitioner shall be promptly notified by special notice. Precautionary action may consist of a suspension of all or a part of a practitioner's privileges, the imposition of conditions or limitations, or a combination of actions.

c. **Voluntary Limitation**. Before imposing precautionary action, the person(s) imposing it should, if practical, afford the affected practitioner the opportunity to voluntarily agree to the proposed action. If the affected practitioner does agree to the action in writing, it shall be effective immediately. In such case, the action shall be treated as voluntary, and not as imposed by the Medical, Staff, though certain reporting may be required under state or federal law.

d. **Corrective Action.** Whenever precautionary action is imposed, the individual imposing it shall, within two (2) business days after its imposition, request that the Executive Committee initiate an investigation, unless the practitioner has voluntarily assented to the limitation.

e. **Ratification**. A precautionary action imposed by other than the Executive Committee is effective but preliminary in nature and expires within five (5) days, unless ratified and made into a summary action by the Executive Committee or the intervening investigation reveals that there are inadequate grounds for corrective action and the precautionary action is withdrawn.

f. **Summary Action**. Only the Executive Committee or Board can impose summary suspension. In determining whether to ratify a precautionary action (and thereby convert it into a summary action) or rescind it, the Executive Committee or Board shall make an effort to interview the affected practitioner and hear any additional facts and support from the practitioner and from the party imposing the precautionary action with the five (5) day period. Following deliberation the Executive Committee or Board shall notify the affected practitioner by special notice of its decision.

g. **Investigation**. Within fourteen (14) days following the imposition of summary action, the Executive Committee shall, on the basis of its preliminary investigation, determine whether further investigation or corrective action proceedings should ensue, and if so, whether the summary action should be lifted, modified or continued during the subsequent investigation and proceedings. If the Executive Committee declines to pursue further proceedings, the summary action shall be lifted unless voluntarily agreed to or incorporated into an agreement with the member.

h. **Reinstatement of Privileges Pending Review**. A member whose clinical privileges have been suspended or limited on a precautionary/summary basis or who has voluntarily requested and accepted limitations in lieu of precautionary/summary action may, at any time during the pendency of the precautionary/summary action, request reinstatement of privileges by delivering a written request to the Executive Committee. Reinstatement of privileges pending completion of the corrective action process shall be a matter within the discretion of the Executive Committee, subject to the ultimate authority of the Board.

i. **Alternative Coverage**. Immediately upon the imposition of precautionary/summary action, the Chief of the Medical Staff will have authority to provide as necessary for alternative coverage for the patients of the practitioner still in the Hospital. The wishes of the patients shall be considered in selection of alternative coverage.

7.13 **AUTOMATIC SANCTIONS**.

a. **Delinquent Medical Records**. A temporary suspension of a practitioner's admitting, co-admitting or outpatient privileges will be imposed automatically five (5) days after notification from the CEO or the Board President of failure to complete medical records within the time periods required by the Medical Staff Rules and Regulations, unless the suspension is waived for good cause by the CEO. This subsection does not limit the ability of the Medical Staff or the Board to take other corrective action when a practitioner fails to properly or timely complete medical records.

b. **Lack of Insurance**. A temporary suspension of a practitioner's privileges shall be imposed automatically for failure to provide, to the satisfaction of the CEO or Executive Committee, continuing evidence of current malpractice insurance as required by these Bylaws.

c. **Action by State or Federal Agency**. Action by the State of Iowa or the federal government revoking, suspending, or limiting a practitioner's license or authority to practice his or her profession, or excluding the individual from participation in the Medicare or Medicaid programs, shall to the same extent, automatically revoke, suspend, or limit, as the case may be, his or her clinical privileges at the Hospital. This provision shall not be interpreted to prevent other appropriate corrective action proceedings in such a case.

d. **Other Grounds**. The Medical Staff Rules and Regulations may provide other grounds leading to automatic suspension of all or a part of a practitioner's clinical privileges.

e. **Alternative Coverage**. Immediately upon the imposition of automatic sanctions, the Chief of the Medical Staff will have authority to provide as necessary for alternative coverage for the patients of the practitioner still in the Hospital. The wishes of the patients shall be considered in selection of alternative coverage.

f. **Duration and Rights**. All automatic sanctions will continue until medical records are completed, where applicable, and in other cases until the practitioner documents to the satisfaction of the Executive Committee and the CEO that the grounds for the sanction no longer exist. The Executive Committee or the CEO shall, upon request, meet with the individual to allow the individual to present any argument, explanation, documentation or other information suggesting that the grounds for the suspension no longer exist. Practitioners whose clinical privileges are automatically suspended for longer than thirty (30) days shall be entitled to the procedural rights set forth in Article VIII.

g. **Sickness or Disability**. Except when resulting from action of the State of Iowa or the federal government as described above, whenever automatic suspension is imposed for reasons beyond the control of the practitioner due to sickness or disability, either the Board President in consultation with the CEO or the Executive Committee may, in their discretion, revoke such suspension and place the practitioner on leave of absence, or take other action which they deem appropriate under the circumstances.

ARTICLE VIII
HEARING AND APPEAL PROCEDURES

8.1 **STATEMENT OF POLICY**. Certain actions and recommendations as listed in this Article VIII may have a material adverse effect on a member's or applicant's membership status or exercise of clinical privileges. This Article VIII sets forth hearing and appeal procedures that are available to members and applicants in connections with such matters. These hearing and appeal procedures are intended to:

a. Provide fairness to the practitioner by assuring the practitioner fair notice, an opportunity to be heard and present information, and an objective hearing forum;

b. Assure that an adverse action or recommendation is based on a fair consideration of the facts following a reasonable effort to obtain the fact;

c. Assure that such actions and recommendations are based on standards and criteria that are consistent with the Hospital's legitimate patient care, legal and operational needs; and

d. Be workable and realistic when considered in light of the size and resources of this Medical Staff, the Hospital, and the Board.

8.2 **RIGHT TO HEARING**. Except as expressly limited by other provisions of these Bylaws, a practitioner shall have the right to request a hearing whenever the Executive Committee makes a formal recommendation or the Board takes action which, if adopted as final action would result in:

a. Denial of Medical Staff membership or clinical privileges, including denial of a requested increase or renewal of membership or clinical privileges, provided that (i) that applicant is in an eligible category and a proper application and all required information was timely submitted, and (ii) this Article VIII does not apply to temporary or disaster privileges or to emergency authority;

b. Suspension or revocation of membership;

c. Limitation, reduction, suspension, or termination of clinical privileges, other than a precautionary action lasting fourteen (14) days or less, and other than temporary or disaster privileges or emergency authority; or

d. Imposition of individual consulting, second opinion or special observation or reporting requirements other than for the purpose of evaluating credentials or performance. No other action or recommendation will entitle the affected individual to a hearing under these Bylaws, although the Executive Committee and Board may, in their discretion, provide a hearing or an alternate forum in cases where a hearing is not required.

8.3 **NOTICE OF ADVERSE ACTION**. In all cases in which the Executive Committee or the Board has taken action or made a final recommendation constituting grounds for a hearing, the CEO shall furnish the practitioner with a written notice of adverse action that: (i) describes the recommendation or action and the general grounds on which such recommendation or action is based; (ii) notifies the practitioner of his or her right to request a hearing; (iii) describes the manner and time limit for requesting a hearing; and (iv) explains the consequences of failing to timely request a hearing. At the same time the CEO should furnish the practitioner with a copy of the Bylaws. The description of grounds may be general, but should identify the standards and conditions in the Bylaws on which it is based. The Executive Committee or Board, as the case may be, may supplement grounds in preparation for the hearing. The notice of adverse action need not list chart numbers, cases, or witnesses.

8.4 **REQUEST FOR HEARING**.

a. **Request by Practitioner**. The affected practitioner shall have thirty (30) days following the date of receipt of the notice of adverse action within which to deliver a written request for a hearing to the CEO. The request for hearing must indicate in what respect, from the affected practitioner's point of view, the action or recommendation is in error and on what points the practitioner wishes to appeal.

b. **Failure to Request a Hearing**. In the event that practitioner does not request a hearing within the time and in the manner prescribed, he or she will be deemed to have accepted the action involved, and it will thereupon be forwarded to the Board for final action without further hearing or appeal.

c. **Notice and Delivery**. Any notice, request or other document required to be given under this Article VIII shall be deemed delivered when:

(1) in the case of notice to the CEO, hand delivered to the CEO at any location or to a member of his or her staff at the CEO's office; mailed to the CEO by registered or certified mail, postage prepaid at the CEO's office; sent by fax to the CEO at the CEO's office; or sent by electronic mail to the CEO at his or her Hospital electronic mail address; and

(2) In the case of notice to the practitioner, hand delivered to the practitioner at any location or to a member of his or her staff at the practitioner's office; mailed to the practitioner by registered or certified mail, postage prepaid at the practitioner's office; sent by fax to the practitioner at the practitioner's fax number on file with the Hospital; or sent by electronic mail to the practitioner at his or her electronic mail address on file with the Hospital.

8.5 **SCHEDULING AND NOTICE OF HEARING**. The CEO shall schedule the hearing and provide notice of the date, time, and place of the hearing. Notice shall be given not less than thirty (30) days prior to the scheduled hearing date. Notice of hearing shall identify, insofar as known, the identity of the hearing committee or hearing officer that will conduct the hearing. Once a request for a hearing is initiated, it is within the Hearing Committee or Hearing Officer's discretion to grant postponements and extensions of time beyond the times permitted in these Bylaws upon a showing of good cause.

8.6 **HEARING COMMITTEE**. When a hearing is requested, the CEO may appoint a Hearing Committee consisting of practitioners as follows:

a. **Appointment.** The CEO after consultation with the Chief of Medical Staff appoints the members of the Hearing Committee. The Hearing Committee should consist of three (3) practitioners, a majority of whom are physicians. When the practitioner requesting the hearing is a non-physician practitioner, reasonable efforts will be made for one member of the Hearing Committee to be a non-physician, preferably but not necessarily of the same profession as the individual requesting a hearing.

b. **Qualifications**. Members of the Hearing Committee:

(1) may not be in direct economic competition with the affected practitioner;

(2) may not have actively participated in prior stages of the proceedings;

(3) may not be expected to be called as key witnesses in the hearing;

(4) may, but need not be, associated with the Medical Staff;

(5) may have prior knowledge of facts relevant to the matter, so long as they indicate such prior knowledge will not interfere with rendering a decision on the basis of evidence present at the hearing; and

(6) may not have other business, family or professional relationships likely to undermine their ability to render a decision on the basis of evidence presented at the hearing.

c. **Establishing Qualifications**. The CEO shall furnish the members of the Hearing Committee with a questionnaire confirming the members: (i) are not disqualified due to any of the factors listed above; (ii) are not aware of any business, family or practice relationship that would undermine their ability to serve; and (iii) will be able to decide the matter based on the evidence produced at the hearing. The completed and signed questionnaires shall become a part of the record. The CEO may remove a member based on responses. The Hearing Officer may make recommendation to the CEO regarding the qualification of fitness of any appointed member of the Hearing Committee to serve, but shall not have authority to appoint or remove members.

d. **Pleadings.** In advance of the hearing, the Hearing Officer shall provide each member of the Hearing Committee with copies of the Bylaws, the notice of adverse action, the request for hearing and the notice of hearing.

8.7 **HEARING OFFICER**. The CEO shall appoint a hearing officer to preside at the hearing. The Hearing Officer shall preferably be an attorney at law, judge, retired judge or other person with appropriate training. The Hearing Officer shall endeavor to maintain proper decorum and assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner. The Hearing Officer shall not deliberate or vote, but may assist the Hearing Committee by advising on the applicable procedures and standards under these Bylaws. The Hearing Officer shall have authority to:

a. advise the Hearing Committee on the standard of review at the hearing and on the procedures and standards applicable to the hearing process and the matter under review;

b. schedule and conduct pre-hearing proceedings;

c. determine the order of or procedure for presenting evidence and statements during the hearing and allot time to the parties;

d. make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence;

e. require the exchange of information, case outlines, witness lists, and exhibits between the parties, and the common marking of exhibits;

f. require that witnesses be sworn and that testimony be taken under oath;

g. request the stipulation of uncontested facts; and

h. if the hearing officer determines that a party to a hearing is not proceeding in an efficient and expeditious manner, take such discretionary action as he or she deems necessary

8.8 **EXPANDED ROLE OF HEARING OFFICER**. The CEO may, after consultation with the Chief of the Medical Staff combine the role of Hearing Committee and Hearing Officer in a single individual who shall be known as Hearing Officer. In such case the Hearing Officer may be either a practitioner or an attorney, judge or retired judge, provided that he or she meets the qualifications in Section 8.6b and, if a lawyer, not represent another client who is in direct economic competition with the practitioner. If the roles are combined, all the duties and powers of the Hearing Committee apply to the Hearing Officer.

8.9 **PRE-HEARING PROCEDURES.**

a. **Outlines of Case**. At any time during the proceedings, the Hearing Officer may require the affected practitioner and the Executive Committee to each submit a case outline setting forth, so far as is then reasonably known, issues which each party proposes to raise at the hearing; witnesses whom each party proposes to call at the hearing and the subject or subjects on which each witness will testify; a description of written or documentary evidence which each party anticipates introducing as evidence at the hearing; a short summary of what the party expects to demonstrate at the hearing in support of its position; and/or the specific result requested from the committee.

b. **Pre-hearing Conference**. Prior to the scheduled hearing, the Hearing Officer shall conduct a pre-hearing conference in person or by conference call to discuss possible stipulations of fact, amendments to the grounds for action or the issues in dispute, and changes in the witness or evidence lists, and to narrow the issues for hearing. The Hearing Officer shall have authority to limit the issues, arguments, witnesses, and exhibits at the hearing to conform to the orders and stipulations at the pre-hearing conference. Failure of either party to appear at and participate in the preliminary meeting shall be deemed to be acceptance of all agreements and decisions made at or as a result of the preliminary meeting.

8.10 **LEGALLY PROTECTED INFORMATION**. To the extent that the evidence at hearing and the information to be provided by the Hospital to the practitioner and his or her legal counsel or experts includes individually identifiable health information protected as such under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") and the regulations issued there under, the CEO and Hearing Officer may condition the furnishing of such information to the practitioner and the practitioner's counsel upon the receipt of signed confidentiality agreements from them in form satisfactory to the Hospital agreeing not to use or disclose such protected information except in connection with the conduct of the peer review proceedings and further agreeing to return all copies at the conclusion of the hearing and appeals process.

8.11 **CONDUCT OF HEARING.**

a. **Cross-Examination and Rebuttal**. No oral testimony shall be offered or submitted to the committee without both the affected practitioner and the Executive Committee having the opportunity to be present, to question the witness, to respond, and to rebut the evidence.

b. **Evidence.** No written evidence, testimony, or documentation shall be considered by the committee, which has not been made available to both parties for rebuttal, or received as evidence at a meeting at which both sides have been present. The decision of the Hearing Committee shall be based upon the evidence.

c. **Representation.** The Executive Committee or the Board, whichever body rendered the decision from which the practitioner has requested the hearing, shall name a spokesman to represent it at the hearing. Each party shall be entitled to be accompanied by and represented at the hearing by an attorney at law or other representative.

d. **Rules of Evidence**. The hearing will not be conducted according to the rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. Each party will have the right to submit memoranda concerning any issue of procedure or fact, and such memoranda will become a part of the hearing record.

e. **Rights of Both Sides**. At the hearing, both sides shall have the right to call and examine witnesses, to introduce exhibits, to cross-examine any witness on any matter relevant to the issues, and to rebut any evidence. If the practitioner requesting the hearing does not testify in his or her own behalf, he or she may be called and examined as if under cross-examination.

f. **Burden of Proof**. At any hearing resulting from an action or recommendation during corrective action proceedings, the spokesperson for the Board or the Executive Committee will have the initial burden of producing evidence in support of its action or recommendation. At any hearing resulting from an action or recommendation during the original application or reappointment processes, and at any hearing following corrective action proceedings once the spokesman has produced the evidence in support of the action or recommendation, the individual requesting the hearing shall have the burden of proving by a preponderance of the evidence that the action or recommendation is arbitrary, capricious, or not supported by the evidence. The Hearing Committee shall uphold the recommendations of the Executive Committee, unless it finds by a preponderance of the evidence following the hearing that such recommendation is arbitrary, capricious or not supported by the evidence.

g. **Committee Members**. Members of the Hearing Committee are authorized to take a participatory role in the proceedings, to question witnesses, to call upon witnesses for information within their possession, to direct the submission of additional evidence and documentation, to question the Executive Committee spokesperson and the affected practitioner, and to see that the record contains all information which the committee considers necessary in order to reach a decision.

h. **Attendance**. Failure without good cause of the affected practitioner who requested the hearing to appear and proceed at the hearing will be deemed to constitute voluntary acceptance of the action or recommendation that prompted the hearing. Failure without good cause of the Board or Executive Committee or its designee to appear and proceed at such a hearing will be deemed to constitute a withdrawal of the recommendation or action involved.

i. **Witness.** The Hearing Officer may order the sequester of witnesses. Testimony of character witnesses and patients who can testify to their confidence in the affected practitioner will not be considered relevant to the proceedings.

j. **Nonpublic Hearing**. Proceedings will be conducted in private, before the parties and their representatives, the Hearing Committee members, and the court reporter.

k. **Record.** The Hearing Committee will maintain a record of the hearing by a professional court reporter, the cost of whose fees shall be shared equally by the Hospital and the affected practitioner. The practitioner is entitled to a copy of the record upon payment of any reasonable charges associated with the preparation thereof.

l. **Recess and Deliberations**. The Hearing Committee may recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, statements, and other submissions required or approved by the Hearing Committee, the hearing shall be closed. The Hearing Committee may thereupon conduct its deliberations in private session and outside the presence of the individual who requested the hearing. At any time prior to rendering its decision, the committee may in its discretion, upon fair notice to each party, reconvene the hearing and receive additional evidence or argument.

m. **Written Statement**. Both parties may submit written statements at the conclusion of the hearing, within time limits established by the committee, and the committee may require the submission of proposed findings or other materials, which the committee deems appropriate. Such materials shall not constitute evidence.

n. **Decision.** A copy of the written decision of the Hearing Committee setting forth the findings on which it is based shall be transmitted to the CEO, who will promptly furnish a copy to the Board, the affected practitioner, and the Executive Committee. The decision of the Committee constitutes the final submission to the Board. Either the affected practitioner or the Executive Committee may appeal the decision of the Hearing Committee to the Board. The Board may accept or reject the decision of the Hearing Committee, but if the Board rejects such decision in a case where neither party has appealed, the Board shall permit the parties, or either of them, to request reconsideration in the form of appellate review before its decision becomes final.

8.12 **HEARING BASED ON ACTION BY BOARD OF DIRECTORS**. When the hearing is based upon action by the Board, the Hearing Committee will be appointed by the CEO after consultation with the Board President, and one member of the committee may be a non-practitioner. The procedure established for hearing based upon final action and recommendation of the Executive Committee shall otherwise be applicable, so far as reasonably possible and otherwise consistent with these Bylaws.

8.13 **TIME LIMITS**. Reasonable effort should be made to conduct the hearing within ninety (90) days following the action or recommendation of the Executive Committee or the action of the Board which prompted the hearing. However, when the request for hearing is received with respect to a practitioner then under precautionary limitation, the hearing should be convened as soon as the arrangements may reasonably be made, preferably not later than thirty (30) days following the request for hearing, and all stated time limits may be shortened accordingly by the Hearing Committee. The decision of the Hearing Committee shall generally be rendered in writing within ten (10) business days following the close of the hearing and submission of all post-hearing statements, and shall be furnished through the CEO to the affected practitioner, the Executive Committee and the Board.

8.14 **APPELLATE REVIEW**.

a. **Appeal Procedure**. Within ten (10) days after receipt of the decision of the Hearing Committee, the affected practitioner or the Executive Committee (or the CEO or any Board member where the hearing has been held before a hearing committee appointed by the Board) may request an appellate review before the Board. The request must be delivered in writing to the CEO, and must also include a brief statement of the reasons for appeal. If appellate review is not requested in such period of time, the parties shall be deemed to have accepted the action involved, and it shall thereupon become final and shall be effective immediately, subject to final approval by the Board.

b. **Time, Place, and Notice**. The CEO will deliver the request for appeal to the President of the Board. The Board will promptly arrange for preparation of the transcript of the hearing. The affected practitioner shall be responsible for paying his or her own cost of preparing and obtaining such transcript. The Board shall thereafter notify the parties of the time, place, and date for appellate review. The appellate review should ordinarily not be more than thirty (30) days from the later of the date of the request of completion of the transcript from the hearing.

c. **Nature of Appellate Review**. The proceedings by the Board are in the nature of an appellate review based upon the record of hearing before the hearing committee, provided that the Board may, in its sole discretion, accept additional oral or written evidence subject to the same rights of cross-examination and confrontation provided at the hearing. Each party has the right to present a written statement in support of its position on appeal on or before the date of the appellate review. In its sole discretion, the Board may allow each party or representative to personally appear and make oral argument. All meetings and proceedings of the Board in connection with appellate review, including the Board's deliberations, may be conducted in closed session to the extent permitted by law and pursuant to legal requirements and procedures for closed session at a Board meeting. The Board may consult with the Hospital CEO and/or with legal counsel, and the Board's legal counsel shall not be disqualified from serving as such by virtue of having served as Hearing Officer (unless serving as decision maker with expanded authority), or as counsel to the Hearing Committee, in the matter at hand. The Board may affirm, modify, or reverse the decision of the Hearing Committee or may refer the matter back to the Hearing Committee for further review and recommendation.

d. **Final Decision**. Within thirty (30) days after the conclusion of the proceedings before the Board, the Board shall render a final decision in writing setting forth the grounds on which it is based, and deliver copies thereof to the CEO of transmittal to the parties and to Chief of the Medical Staff. The decision of the Board is final and is effective immediately.

e. **Right to One Hearing and One Appellate Review Only**. No applicant, member, or practitioner is entitled as a matter of right to more than one hearing on any single matter which may be the subject of a hearing, without regard to whether such subject is the result of action by the Executive Committee or Board or a combination of acts of such bodies, or more than the one appellate review before the Board on any single matter which may be the subject of an appeal.

8.15 **REPORTING**. Following conclusion of the proceedings the CEO will make any required report under state or federal law, indicating any final adverse action involving the membership or privileges of the affected practitioner.

ARTICLE IX
RESERVED AUTHORITY

Notwithstanding any other provision of the Bylaws, the Board of Directors reserves the right to initiate or take action or to take over any application investigation, or corrective action proceeding, when, after reviewing the matter with the Executive Committee (i) the Executive Committee requests it to do so, or (ii) the Board determines the Executive Committee is unable or unwilling to act in a particular situation, or (iii) the matter involves Hospital policy or legal compliance rather than competence or professional conduct potentially adversely affecting patient welfare. When acting under this provision, the Board of Directors shall follow procedures and afford practitioners procedural rights similar to those afforded under these Bylaws.

ARTICLE X
OFFICERS OF THE MEDICAL STAFF

10.1 **NUMBER AND QUALIFICATION**. The officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff and the Secretary-Treasurer. Officers must be members of the Active Staff in good standing at the time of their nomination and election. Failure to maintain such status shall immediately create a vacancy in the office involved.

10.2 **CHIEF OF STAFF**. The Chief of Staff shall:

a. act in coordination and cooperation with CEO in all matters of mutual concern within the Hospital;

b. call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;

c. be responsible for the enforcement of Medical Staff Bylaws, Rules, and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested;

d. attend meetings of the Board when necessary or called upon to do so, and may attend meetings in other cases and represent the views, policies, needs, and grievances of the Medical Staff to the Board and to the CEO;

e. receive and interpret the policies of the Board for the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;

f. assure continuing review of the professional performance of all Staff members with clinical privileges and report regularly to the Medical Staff;

g. be responsible for implementation of actions taken by the Medical Staff;

h. appoint members of committees of the Medical Staff and designate committee chairs;

i. serve as Chair of the Executive Committee;

j. serve as the appointed Medical Director for the Hospital; and

k. carry out such other duties as are assigned to the Chief of Staffin these Bylaws or which normally pertain to the office of Chief of Staff.

10.3 **VICE CHIEF OF STAFF**. The Vice Chief of Staffshall, in the absence of the Chief of Staff, or during any temporary ineligibility or inability of the Chief of Staffto serve or any conflict of interest of the Chief of Staff, assume to that extent the duties and the authority of the Chief of Staff, and shall assist the Chief of Staffin the performance of his or her duties upon request.

10.4 **SECRETARY-TREASURER**. The Secretary-Treasurer shall keep accurate and complete minutes of all meetings of the Medical Staff and of the Active Staff. A copy of minutes of all meetings shall be forwarded to the CEO. He or she shall attend to all correspondence and perform such other duties as ordinarily pertain to the office. The Secretary-Treasurer shall be the secretary of the ad hoc Bylaws committee whenever it convenes. The Secretary-Treasurer shall collect dues, if any, and be the financial custodian of Medical Staff funds and make a report of the same at the annual meeting of the Medical Staff.

10.5 **ELECTION AND TERM OF OFFICE**. The officers of the Medical Staff are elected at the annual meeting of the Medical Staff, take office at the first meeting in the next succeeding Medical Staff year, and serve until their successors take office in the following year. Election of officers is subject to confirmation by the Board. In the event of failure of confirmation, the person then holding the office will continue in office until another person has been elected by the Medical Staff and approved by the Board. Vacancies in the office during the year will be filled by vote of the Executive Committee, subject to confirmation by the Board.

10.6. **REMOVAL**. The Active Staff may remove any officer at any meeting by a majority vote of members of the Active Staff present and voting at such meetings, a quorum being present, provided notice of the proposed action is included in notice of the meeting.

ARTICLE XI
COMMITTEES OF THE MEDICAL STAFF

11.1 **EXECUTIVE COMMITTEE**.

a. **Composition**. The Executive Committee consists of the Active Staff plus one member of the Affiliate Staff with voting rights except as provided in Section 3.10.

b. **General Duties**. The Executive Committee shall:

(1) Act on behalf of the Medical Staff in the interim between meetings of the Active Staff;

(2) Act for the Medical Staff in verifying, investigating, and evaluating applicants and applications for membership and privileges and in making recommendations thereon;

(3) Act for the Medical Staff in investigating members and in pursuing and imposing corrective action;

(4) Take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective action where warranted;

(5) Act for the Medical Staff in other matters as requested by the Active Staff;

(6) Arrange for the periodic review, at least every other year, of these Bylaws, Rules and Regulations, and recommend necessary amendments to the Medical Staff; and

(7) Carry out all other duties assigned to the Executive Committee in these Bylaws or by the Board.

c. **Credentials Functions**. The Executive Committee shall act as the Credentials Committee, and in that capacity shall:

(1) Review all applications for Medical Staff membership and clinical privileges; and review applications for reappointment to the Medical Staff and renewal of privileges, review all applications for Allied Health Professionals, and develop recommendations as to classification of staff and the extension of privileges, pursuant to the procedures set forth in these Bylaws; and

(2) Promptly process all requests for corrective action, conduct investigations thereon, and make appropriate recommendations to the Board, pursuant to the procedures set forth in these Bylaws.

d. **Meetings.** The Executive Committee shall meet at least ten (10) times per year on the call of the Chief of Staff and keep records of all proceedings and actions.

11.2 **OTHER COMMITTEE FUNCTIONS**. The Active Staff members, acting as a committee of the whole, are responsible for all other Medical Staff committee functions, with assistance when requested from the Affiliate Staff, other practitioners, Allied Health Professionals, or employees or contractors of the Hospital. Committee meetings will be held in conjunction with regular monthly Staff meetings. Any of the enumerated functions may be delegated to subcommittees, the chair of the subcommittee to be appointed by the Chief of Staff. However, any committee performing peer review functions shall be directly accountable to and shall regularly report directly to the Executive Committee. The Active Staff members must meet at least ten (10) times per year, attend to each of the enumerated functions either monthly or on other established schedules, and maintain permanent written records of all actions taken. The specific functions to be carried out under the committee structure approved by the Executive Committee include, in addition to other functions designated from time to time, the following:

a. **Medical Records**. Examine medical records and be responsible for their maintenance at the required standards. Currently maintained records will be reviewed to assure that they properly describe the condition and progress of the patient, therapy provided, and outcomes and that they meet the criteria of medical comprehension of the case in the event of transfer of physician responsibility for patient care.

b. **Surgical Case Review**. Review justification for operation in all instances whether or not a surgical tissue is removed, and review compliance by the members of the Medical Staff with consultation requirements for surgery. Take appropriate action where necessary on the agreement or disagreement between preoperative, post-operative and pathological diagnoses, and whether the surgical procedures undertaken in the Hospital appear justified or not.

c. **Utilization Review**. Conduct utilization review in accordance with the Hospital's Utilization Review Plan. This shall include, at a minimum, conducting the following activities:

(1) Develop a Utilization Review Plan that is appropriate to the Hospital and that meets current requirements of law and regulations. The Plan must include provision for review of appropriateness and medical necessity of admission, continued Hospital stays, and supportive services, discharge planning, and data collection and reporting.

(2) Monitor the performance of individual members and practitioners under the guidelines of good medical care. In discharging this function, the Committee shall recommend individual cases to the Quality Improvement Committee for further review or action.

(3) Prepare monthly reports including at least a summary of the findings of, and specific recommendations resulting from, the Utilization Review Program.

d. **Pharmacy and Therapeutics**.

(1) Be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard;

(2) Assist in the formulation of professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital; and

(3) Provide a means to review requests for off-formulary or non-FDA approved uses of drugs at the Hospital

e. **Infection Control**. Be responsible for the surveillance of inadvertent Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventive and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities.

f. **Emergency Room**. Formulate and implement policies and procedures for the emergency and outpatient departments and draw up and maintain an emergency service roster of the Medical Staff to provide continuous or "on-call" medical service in the emergency room. Consult with and support Hospital administration with respect to compliance with the Emergency Medical Treatment and Active Labor Act ("EMTALA").

g. **Blood Usage**. Review all blood transfusions for proper utilization, with particular attention to the use of whole blood versus component blood elements under the direction of the consulting pathologist.

h. **Disaster Planning**. Be responsible for disaster planning. In cooperation with key Hospital personnel, prepare and periodically review a written plan to safeguard patients in the event of an internal disaster and a written plan for the care, reception, and evacuation of mass casualties during an external disaster. Make recommendations to the Board and the CEO and periodically review and update the plans and the Hospital's preparedness in the event of internal or external disaster.

i. **Quality Improvement**. Conduct Quality Improvement activities in accordance with the Hospital's Quality Improvement Plan. The Quality Improvement Plan shall be structured and implemented to include systematic monitoring and evaluating of the quality and appropriateness of the care of patients served by the Hospital and the clinical performance of all individuals with clinical privileges. Problems identified in the quality improvement process involving individual practitioners will be referred to the Executive Committee.

j. **Organ and Tissue Donation**. Conduct a review of the policies and procedures related to organ and tissue donation and advise staff in these areas as needed.

11.3 **ATTENDANCE AND PARTICIPATION**. The Active Staff should meet at least ten (10) times annually to discharge these Committee functions, with quarterly meetings to include the pathologist. All Committee functions shall be conducted in conjunction with Medical Staff meetings. Specific representatives of Administration, such as the Director of Nursing and the Director of Medical Records shall be assigned corresponding responsibility to assist with Active Staff consideration of these subjects. One-half (1/2) of the members appointed to a committee shall constitute a quorum for conducting the business of the Committee.

11.4 **SPECIAL COMMITTEES**. The Executive Committee, from time to time, may designate special committees for such purposes and such duration as it shall deem appropriate consistent with these Bylaws. All members of the Medical Staff, in any category, as well as other practitioners, Allied Health Professionals, and contractors and employees of the Hospital where appropriate may be appointed to special committees.

ARTICLE XII
MEETINGS OF THE MEDICAL AND ACTIVE STAFFS

12.1 **ANNUAL AND REGULAR MEETINGS**. The annual meeting of the Medical Staff will be held in December of each year. During this meeting, officers for the ensuing year will be elected. There will be at least ten (10) meetings of the Active Staff annually, one of which will be the annual meeting of the Medical Staff. Other meetings of the entire Medical Staff, or of categories of the Medical Staff other than the Active Staff, will be called as needed.

12.2 **SPECIAL MEETINGS**. Special meetings of the Medical Staff or of the Active Staff may be called at any time by the Chief of Staff or the President of the Board, or by any two members of the Active Staff. Notice of any special meeting should be given, insofar as practical, to each member of the Active Staff at least forty-eight (48) hours prior to the meeting.

12.3 **QUORUM**. One-half (1/2) of the members of the Active Staff shall constitute a quorum for the transacting of all business of the Medical Staff or Active Staff.

12.4 **AGENDA**. The agenda of the regular meetings of the Medical Staff shall be established by the Chief of Staff.

12.5 **AGENDA FOR SPECIAL MEETINGS**. The agenda for special meetings will be:

a. reading of the notice calling the meeting;

b. transaction of the business for which the meeting was called; and

c. adjournment.

ARTICLE XIII
ALLIED HEALTH PRACTITIONERS

13.1 **DESIGNATION**. AHPs are individuals who are duly licensed or certified by the State of Iowa in one or more of the health care sciences to provide direct patient care services under the supervision or upon the orders of another licensed category of practitioner, such as physicians. AHPs do not qualify for clinical privileges. Their services in the Hospital are based upon orders from and supervision of another practitioner. AHPs therefore include categories such as registered nurses, radiology technicians, nuclear medicine technicians, speech therapists, physical therapists, and occupational therapists. The Medical Staff and CEO may collaborate in developing special qualifications for categories of AHPs, which may be included in the Rules and Regulations. AHPs will ordinarily provide services at the Hospital, as employees of the Hospital, as providers furnished under a written contract with the Hospital, or as independent practitioners. In all cases, AHPs must be credentialed before they may provide patient care services.

13.2 **EMPLOYED AHPS**. The Hospital, through its regular employment and HR channels, will credential and verify physician supervision of the employed AHPs. The Hospital may request assistance from the Medical Staff in establishing criteria or assessing individual qualifications.

13.3 **CONTRACTED AHPS**. The Hospital, through contract, following consultation with the Executive Committee, will establish qualifications for contracted AHPs and include such qualifications in any contracts under which the services of contracted AHPs are obtained. Contracted AHPs will then be credentialed in the same manner as employed AHPs.

13.4 **INDEPENDENT AHPS**. Independent AHPs shall be credentialed by the Executive Committee based on category-specific criteria included in the Rules and Regulations. Independent AHPs may be granted practice authority on recommendation of the Executive Committee with approval by the CEO. Independent AHPs shall provide patient care services at the Hospital only upon the orders or request of a privileged member of the Medical Staff. Applications for independent practice authority shall be on an approved form, and the applicant shall have the burden of providing all requested information.

13.5 **ATTENDANCE AND PARTICIPATION**. AHPs may be appointed to committees or invited to attend and participate in Medical Staff affairs, and when so appointed or invited, shall attend and participate.

13.6 **LIMITATION ON RIGHTS**. AHPs are not eligible for membership or clinical privileges. AHPs are not covered by the full membership, application, privileging, or hearing and appeals provisions in these Bylaws, but shall be entitled to an interview with the Executive Committee and CEO before final action denying a request for independent practice authority or action limiting, curtailing, or withdrawing existing practice authority.

13.7 **STUDENTS AND RESIDENTS**. Students and residents functioning at the Hospital as part of a practicum, graduate education, or training experience shall do so under the supervision of designated personnel and subject to any limitations imposed by the Hospital or in the contract or other arrangement between the Hospital and sponsoring educational or training program. Residents providing services on a moonlighting basis outside of the scope of an approved graduate medical education or residency program shall be required to obtain temporary privileges.

ARTICLE XIV
PROCTORS, SUPERVISORS AND MONITORS

Individuals who are designated to proctor, supervise, or monitor an applicant or a member under these Bylaws are carrying out a Medical Staff function in support of the Medical Staff's peer review responsibility. Assignment to or discharge of any such role shall not imply or have the effect of creating a physician-patient relationship or a duty on the part of the proctor, supervisor or monitor to participate or intervene in the care of an individual patient.

ARTICLE XV
CODE OF CONDUCT

15.1 **POLICY.** The Medical Staff hereby expresses its strong support for the Hospital and Medical Staff Code of Conduct and policy that all individuals within the Hospital's facilities shall be treated courteously, respectfully, and with dignity. The Hospital and Medical Staff intend to provide a work environment that is pleasant, professional, and free from intimidation, hostility, harassment or other offenses. Disruptive and/or inappropriate conduct by Medical Staff and Allied Health Professionals undermines Hospital operations and the quality of care to patients, and depending on the nature of the conduct, can cause substantial legal liability for the Hospital and practitioner. Accordingly:

a. All Medical Staff and Allied Health Professionals are subject to the Hospital and Medical Staff Code of Conduct. Disruptive and/or inappropriate conduct will not be tolerated.

b. Practitioners are expressly prohibited from retaliating in any manner against a member of Hospital's workforce who makes a complaint or provides information to the Hospital or the Executive Committee concerning conduct that may be considered disruptive, inappropriate or constitute sexual harassment.

c. The Executive Committee and CEO shall jointly investigate any complaint alleging violations of the Code of Conduct. The CEO and/or the Board may take over the investigation at the request of the Executive Committee or on their own initiative and impose sanctions, including corrective action, if they deem it necessary to protect the interests served by the Code of Conduct.

d. Violation of the Code of Conduct may result in denial or revocation of membership and privileges, or any lesser sanction.

15.2 **HEARING RIGHTS**. Corrective action arising under this section is subject to the practitioner's rights in Article VIII, if the action taken is one described in Section 8.2 thereof.

ARTICLE XVI
IMPAIRED PRACTITIONERS

16.1 **PURPOSE**. The purpose of this Article is to establish procedures for intervention when a practitioner's professional abilities may be impaired. The goals of these procedures are to preserve quality and safety in the delivery of patient care, and preserve the reputation and professional practice of the practitioner to the greatest extent possible.

16.2 **DEFINITION**. For purposes of these Bylaws, the term "impaired practitioner" shall mean a Medical Staff member whose ability to render patient care safely and effectively is (or appears to be) adversely affected by a physical, mental, emotional or chemical impairment.

16.3 **INTERNAL REPORTING AND ACTION**. Any member of the Medical Staff, the CEO, and any other interested party who believes that a practitioner may be impaired or has facts suggesting impairment shall report such belief or facts with all supporting information to the Chief of Staff and the CEO. The Chief of Staff and the CEO shall promptly meet to determine what action to take. Such action may include any action authorized elsewhere in these Bylaws, a private meeting and voluntary resolution with the affected practitioner, a referral to the Executive Committee, or the appointment of and referral to an ad hoc committee as described below. No person who makes a good faith report or assists in any subsequent investigation or action may be subject to any form of discipline or retaliation for doing so. If the suspected impairment involves the Chief of Staff, the report shall be made to the Secretary, who shall act on the matter in place of the Chief of Staff.

16.4 **AD HOC COMMITTEE**.

a. **Committee Structure and Functions**. The Chief of Staff, in consultation with the CEO, may appoint an ad hoc committee to render professional assistance to an individual practitioner who is, or who may be, impaired, with the goal of assuring continuous quality patient care without the necessity of formal corrective action. The Chief of Staff and CEO shall determine the Committee's assignment and authority, which may include authority:

(1) to investigate whether an impairment exists, which may include meeting with the affected practitioner and others with relevant information, reviewing charts, requesting a health assessment, proctoring or observing the practitioner or any other steps deemed useful by the committee;

(2) where an impairment is found to exist, to meet with-or otherwise attempt to cause the practitioner to recognize and deal with the impairment;

(3) to enter into a written agreement with a practitioner outlining steps which such practitioner has voluntarily agreed to take in response to an impairment, including voluntary limitations on Medical Staff membership, clinical privileges or other practice authority, and thereafter to monitor compliance with such an agreement;

(4) to provide or arrange for ongoing assistance to practitioners who have entered into voluntary agreements and who are complying therewith;

(5) to work jointly with the practitioner and the state Licensee Assistance Program, ("LAP") whenever it is agreed that referral to the LAP would be appropriate; and

(6) to refer cases to the Executive Committee for further action at any time if the committee determines that it is unable to resolve the issue with the voluntary cooperation of the practitioner, or the practitioner fails to comply with any agreement made with the committee.

b. **Committee Privileges and External Reporting**. The ad hoc committee described herein is a peer review committee under these Bylaws; under Iowa law; and under HCQIA. All records and proceedings of the Committee shall be privileged and confidential to the maximum extent permitted by law. The Committee will not have authority to impose binding, non-voluntary corrective action, and therefore no action taken by the Committee will be reportable to the National Practitioner Data Bank or the State Department of Health. Consistent with Iowa law, members of the Committee or witnesses before the Committee will not be required to report an impaired practitioner to the Department of Health as a result of information learned in connection with Committee proceedings. This does not excuse a duty to report, if any, arising from first-hand knowledge obtained outside of Committee proceedings.

16.5 **EXECUTIVE COMMITTEE**. This Article does not alter the Medical Staff Executive Committee's authority under other provisions of these Bylaws (or the CEO's authority in the case of impaired employees) to investigate and take action as deemed appropriate in any case coming to their attention.

ARTICLE XVII
RULES AND REGULATIONS

The Medical Staff may adopt such Rules and Regulations as may be necessary for the proper conduct of its work. Such Rules and Regulations may be adopted and amended without previous notice by the majority vote of those members of the Active Staff present and voting, at any regular meeting or at a special meeting called for such purpose. The Rules and Regulations will become effective upon approval by the Board. The Rules and Regulations will be construed in a manner consistent with these Bylaws, and in the event of any irreconcilable inconsistency, these Bylaws will control.

ARTICLE XVIII
AMENDMENTS

These Medical Staff Bylaws may be amended at any regular or special meeting of the Active Staff of which written notice of such amendments has been given to each member of the Active Staff at least two weeks prior to the meeting, upon receipt of two-thirds vote of those members of the Active Staff present and voting, a quorum being present. Amendments to the proposed amendments may be entertained and acted upon at any such meeting without prior notice. The amendments to the Medical Staff Bylaws shall become effective upon approval by the Board. The Executive Committee with approval of the CEO shall have authority to make technical and typographical corrections to these Bylaws to correct errors and omissions.

ARTICLE XIX
ADOPTION AND EFFETIVENESS OF MEDICAL STAFF BYLAWS AND AMENDMENTS

These Medical Staff Bylaws and any amendments thereto shall become effective when approved by the Active Staff and the Board of Directors, and when so adopted and approved shall have full force and effect, replacing all previous Medical Staff Bylaws of the Hospital.

AMENDED and RESTATED by the Medical Staff on April 21, 2021

Chief of Staff _____

Vice-Chief of the Medical Staff _____

APPROVED by the Board of Directors on April 26, 2021

Chair of the Board of Directors _____

Vice-Chair of the Board of Directors Pauline A. Shatek